

Registration District No. 765

Primary Registration District No. 6266

Registrar's No. 19

1. PLACE OF DEATH:

(a) County St. Clair
 (b) City or town Osceola
 (c) Name of hospital or institution:
County Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 months
 (Specify whether _____)
 In this community _____
 years, months or days 150

8. (a) PRINT FULL NAME William Albert GINN
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Luey Conn 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 17 1930
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 11 23 hr. _____ min. _____

9. Birthplace St. Clair County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
 12. Name James D. Slom
 13. Birthplace Morgan Co. Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Culbertson
 15. Birthplace Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. H. Ginn
 (b) Address Osceola Mo.

17. (a) Burial (b) Date thereof May 12 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Mo.
 18. (a) Signature of funeral director Joseph H. Ginn
 (b) Address Osceola Mo.

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Clair
 (c) City or town Osceola Mo. (Rural?)
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 10
 year 1940 hour 10 PM minute _____ M.

21. I hereby certify that I attended the deceased from Jan, 1940, to May 10, 1940
 that I last saw him alive on May 10, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 year

Due to _____
 Due to _____

Other conditions Had another slow Hemorrhage beginning
 (Include pregnancy within 3 months of death)

Major findings: May 6 - 1940
 Of operations _____
 Of autopsy no

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) _____
 While at work _____ (e) Means of injury _____

23. Signature Ruth Ginn (M. D. or other) _____
 Address Osceola Mo Date signed 5-20 1940

MAKING PERMANENT USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1940 I 11811

RECEIVED
District Health Officer No. 714
District File Number 6-40-858
Date Filed 8-18-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Paul Finston

Licensed Embalmer No. 3990

P. O. Address Collins, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19406

Registration District No. 765

Primary Registration District No. 6266

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
WENNA MOORE

1. PLACE OF DEATH:

(a) County... *St. Clair*

(b) City or town... *Osceola T.P.*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME *Wm Albert Glimm*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *m* 5. Color or race *wh*

6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 11 23 h. min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *5-20-40* (b) *Ruth Seever*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

(d) Street No.....
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month *May* day *10*
year *1940* hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work..... (Specify type of place)

(e) Means of injury.....

23. Signature *Ruth Seever* (M. D. or other).....
Address *Osceola Mo* Date signed.....

SUPPLEMENTAL

S-19406