

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.

JUL 12 1940

Registration District No. 274

Primary Registration District No. 4865

Registrar's No. 954

1. PLACE OF DEATH

(a) County St. Francois

(b) City or town Flat River Mo

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

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

In this community _____
years, months or days 890

3. (a) PRINT FULL NAME Mary Ellen Ames

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Raymond

6. (c) Age of husband or wife if alive 62

7. Birth date of deceased May 22 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 0
If less than one day _____ hr. _____ min.

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

10. Usual occupation Lab.

11. Industry or business _____

MOTHER FATHER

12. Name Daniel Overton

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

14. Maiden name Josephine Armand

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

16. (a) Informant's signature Raymond Ames

(b) Address Flat River Mo

17. (a) _____ (b) Date thereof _____
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation near Bonne Terre Mo

18. (a) Signature of funeral director Baldwell

(b) Address Flat River Mo

19. (a) 6/28/40 (b) O. B. Harner
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois

(c) City or town Flat River
(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 5 day 22
year 40 hour 10 minute 55 P. M.

21. I hereby certify that I attended the deceased from 4-10, 1940, to 5-22, 1940
and that death occurred on the date and hour stated above.

21. I hereby certify that I attended the deceased from _____ to _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration unk.

Due to gastrointestinal

Due to Ch. Cystitis

Other conditions 4/6
(Include pregnancy within 3 months of death)

Major findings: none

Of operations _____

Of autopsy none

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? 697

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

23. Signature W. C. Gaeke (M. D. or other) _____
Address De Sloger Mo Date signed 5-23-40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.