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5-17-39  
P-1 X21492

NOV 23 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26181

State File No. \_\_\_\_\_

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 141

1. PLACE OF DEATH:

(a) County St. Francois *St. Francois*  
(b) City or town Near Farmington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital No. 4 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 yrs. 4 mo. 1 day  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau  
(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.

3. (a) PRINT FULL NAME Holy Cross (John Doe)

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years Months Days If less than one day  
About 72 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None (A tramp) 9

11. Industry or business \_\_\_\_\_ 9

MOTHER FATHER { 12. Name Unknown 1

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 Records of State Hospt. #4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 7-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cemetery of State Hospt. #4

18. (a) Signature of funeral director C. Hugo Cozean  
(b) Address Farmington, Mo.

19. (a) Aug 5-1940 (b) T.B. Robinson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 11  
year 1940 hour 1 minute 25 P. M.

21. I hereby certify that I attended the deceased from 1-1, 1939 to 7-11, 1940;  
that I last saw him alive on 7-11, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Atherosclerotic Heart Disease with Hypertension

Due to Generalized Atherosclerosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 9 5 12

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? 604  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J.R. Mulvey (M. D. or other) 1/20  
Address Farmington, Mo. Date signed \_\_\_\_\_

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

**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..... Not embalmed

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.**