

FILED SEP 24 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28850

State File No. _____

Registration District No. _____

424

Primary Registration District No. _____

5579

Registrar's No. _____

I. PLACE OF DEATH:

(a) County: Jefferson

(b) City or town: Platcher Mo

(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 2

(Specify whether)

In this community _____ years, months or days 5 2 1

3. (a) PRINT FULL NAME Louis E. Mickelson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: m 5. Color or race: W

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

7. Birth date of deceased: July 2 1939

8. AGE: Years 1 Months 1 Days 18 If less than one day hr. _____ min. _____

9. Birthplace: Platcher Mo

10. Usual occupation _____

11. Industry or business _____

12. Name: Jal Mickelson

13. Birthplace: Richwoods Mo

14. Maiden name: Blanche Kulas

15. Birthplace: Richwoods Mo

16. (a) Informant: Jal Mickelson

(b) Address: Platcher Mo

17. (a) _____ (b) Date thereof: Aug 17 1940

(c) Place: burial or cremation: Richwoods

18. (a) Signature of funeral director: Sparks

(b) Address: Platcher Mo

19. (a) _____ (b) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jefferson

(c) City or town: Platcher Mo

(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.? Native years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16 1940

21. I hereby certify that I attended the deceased from 8-5 1940 to 8-16 1940

that I last saw him alive on 8-15 1940

and that death occurred on the date and hour stated above.

Immediate cause of death: Dementia

Duration

Due to: Tuberculosis!

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 305

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature: W. W. Parker (M. D. or other) _____

*Address: Richwoods Date signed: 8-17-40

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

MOTHER FATHER

23

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.

Registration District No. **424**

Primary Registration District No. **2579**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Jefferson**
(b) City or town **St. Louis River**
(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 **Louis E. Michelson**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years Months Days If less than one day
1 1 14 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
{Burial, cremation, or removal}

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **16** 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 _____ day and hour stated above.

Immediate cause of death **Dysentery**

Tuberculosis

Due to **bowels**

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) **25**

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? _____

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

23. Signature **O. W. Parker** (M. D. or other) _____
Address **Ridgewood** Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

No. 2B
2-21-40
I X2232

MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28850
Registrar's No. 141

Registration District No. 424

Primary Registration District No. 5279

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Big River T.P.
(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.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Louis E. Michelson

3. (b) If veteran, name war. 3. (c) Social Security No.

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

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years Months Days If less than one day
1 1 14

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 (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Oct. 22-40 (b) A. H. Eaton
(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 Aug day 16
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19
that I last saw him alive on 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

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 R. W. Parker (M. D. or other)
Address Richwoods, Mo. Date signed

Duration
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL