

FILED OCT 23 1940

STANDARD CERTIFICATE OF DEATH

State File No. 32845

Registration District No. 677 Primary Registration District No. 4403 Registrar's No. 103

1. PLACE OF DEATH:

(a) County Rolla
(b) City or town Rolla
(c) Name of hospital or institution: Pelee McFarland Memorial Hospital
(d) Length of stay: In hospital or institution Hospital
In this community 1 years, months or days

8. (a) PRINT FULL NAME Charles Albert Pines

8. (b) If veteran, name war _____ 8. (c) Social Security No. ✓

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

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

7. Birth date of deceased July 31, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 0 22 hr. min.

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

10. Usual occupation Carnival operator

11. Industry or business 4

12. Name Charles Pines

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

14. Maiden name Sarah Jane Pines

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

16. (a) Informant Harry Pines

(b) Address Waterloo, Iowa

17. (a) Buried (b) Date thereof Aug. 25, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waterloo, Iowa

18. (a) Signature of funeral director Hull & Son

(b) Address Rolla, Mo.

19. (a) Aug 23, 1940 (b) Jos. F. Ryker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County _____
(c) City or town Waterloo
(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 23
year 1940 hour 10:35 minute _____ A. M.

21. I hereby certify that I attended the deceased from Aug 18, 1940, to Aug 23, 1940
that I last saw him alive on Aug 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial valve failing to close

Due to _____

Due to _____

Other conditions Hydrocele
(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 [Signature] M. D. or other _____
Address Rolla, Mo. Date signed 8/23/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number...1040986...

Date Filed.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32845

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. _____

1. PLACE OF DEATH:

(a) County P. Phelps
(b) City or town Rolla Town
(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 Charles Albert Pines

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

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

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 61 Months _____ Days 22 If less than one day _____ 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) Feb. 6, 1941 (b) Jos. F. Ayers
(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 23
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that 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 _____

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 A. Sidney McFarland M.D.
(M. D. or other)

Address Rolla Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

PAIENNA MORGAN PERMANENT RECORDS

SUPPLEMENTARY

