

Registration District No. 773

DEC 11 1940

Registration District No. 6018A

Registrar's No. 194

1. PLACE OF DEATH:

(a) County 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
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 22 days
(Specify whether)
 In this community 5
years, months or days

2. USUAL RESIDENCE OF DECEASED:

State Missouri (b) County Madison
 (c) City or town Fredericktown
(If outside city or town limit, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 15
 year 1940 hour 2 minute 50 P. M.

21. I hereby certify that I attended the deceased from 11-15, 1940, to 11-15, 1940;
 that I last saw him alive on 11-15, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 day
 Due to Chronic Heart Disease with Hypertrophy, Hypertension & Decompensation ?
 Due to Arteriosclerosis, generalized and marked ?
 Other conditions Pericarditis with cardio-vascular disease 3 months
(Include pregnancy within 3 months of death)

Major findings: Arteriosclerosis, marked; bronchopneumonia
 Of autopsy 45B
 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?
699
(Specify type of place)
 While at work? C.C. Art
(a) (b) Means of injury

23. Signature C.C. Art (M. D. or other) M.D.
 Address Farmington, Mo. Date signed 11/20/40

3. (a) PRINT FULL NAME R. N. Faucette
 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 separated
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 2 1890
(Month) (Day) (Year)

8. AGE: Years 50 Months 75 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business _____

12. Name Unknown

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 Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 11-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery of State Hospt. #4

18. (a) Signature of funeral director Richardson Funeral Home

(b) Address Farmington, Mo.

19. (a) Nov 19-1940 (b) R. N. Robinson
(Date received local registrar) (Registrar's signature)

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

4

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 Dugal*

Licensed Embalmer No. *4120*

P. O. Address *Germington, Va*

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. 39652

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town St. Francois
(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

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

ROBERT Faucetta

3. (b) If veteran name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH

Month 11 day 15
year _____ hour _____ minute _____ M.

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

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex m 5. Color or race w

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

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
30 5 13 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

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? (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) _____ of injury

23. Signature A.C. Aust (M. D. or other) _____
Address Farmington, Mo. Date signed _____

SUPPLEMENTAL

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

LYLE MOORE

1940

5-39652