

FEB 17 1941

Registration District No. 421Primary Registration District No. 5575WRegistrar's No. 7

## 1. PLACE OF DEATH:

- (a) County Jefferson  
 (b) City or town Crystal City  
 (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 65 years years, months or days)3. (a) PRINT FULL NAME Barah E. DeHeare

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Andrew C DeHeare 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 12 1849  
 (Month) (Day) (Year)

8. AGE: Years 91 Months 8 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jefferson Co. Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Joseph Medley13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)14. Maiden name Katherine Patterson15. Birthplace N. Carolina  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature George DeHeare(b) Address Crystal City Mo.17. (a) Burial (b) Date thereof 1-26-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Festus Mo.18. (a) Signature of funeral director Walter V. Vengard(b) Address Festus Mo.19. (a) 1-28-1941 (b) J. E. Rutledge  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jefferson(c) City or town Crystal City 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. 91 years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
 year 1941 hour \_\_\_\_\_ minute 11:15 M.

21. I hereby certify that I attended the deceased from July 15  
July 23, 1941, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on July 23, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration \_\_\_\_\_

Due to HeartDue to Severely

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) Means of injury \_\_\_\_\_

23. Signature J. P. Russell (M. D. or other) \_\_\_\_\_Address Crystal City Mo Date signed 1-28-41

109

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.....

*A. S. Wenzel*

Licensed Embalmer No. 3010

P. O. Address.....

*Foster mo*

**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. **3046**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **421**

Primary Registration District No. **5275<sup>a</sup>**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Jefferson city**  
(b) City or town **Crystal city**  
(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.  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Sarah E De Beare**

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

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

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 **91** Months **8** Days **11** If less than one day 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) \_\_\_\_\_ (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 **Jan** day **21** year \_\_\_\_\_ 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 **Hypostatic pneumonia**

**bronchial**

Due to **Weak heart**

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death) **107**

Major findings: Of operations.

Of autopsy.

Duration

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) Means of injury.

23. Signature **J F Donnell** (M. D. or other)

Address **Crystal city** Date signed **107**

SUPPLEMENTAL COPY

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

MOTHER FATHER

