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23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 24 1941

Registration District No. 4

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6n 71

State File No. 32736

Registrar's No.

1. PLACE OF DEATH:

(a) County: Shannon

(b) City or town: Eminence Mo Dr. 1.0
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: 20 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Shannon 101

(c) City or town: Eminence Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No.: Rural 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: George W Custer

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

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

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Not Known (Month) (Day) (Year)

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

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

10. Usual occupation: Farm Laborer

11. Industry or business:

FATHER
12. Name: George W Custer Sr.
13. Birthplace: Not Known
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Melvina Johnson
15. Birthplace: Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Fred Rothe

(b) Address: Wentzville Mo,

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Sept 10 41 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~: Warrenton Mo

18. (a) Signature of funeral director: John F Duncan

(b) Address: Mtn View, Mo.

19. (a) 9-13-41 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9th year 1941 hour 6 minute a 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 date and hour stated above.

Immediate cause of death: Concussion due to accidental fall

Due to:

Due to: alcoholism chronic Myocarditis

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

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: 101

(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? (Specify type of place)

While at work? (e) Means of injury: 3

23. Signature: W. D. Rallins M.D. Coroner (M. D. or other)

Address: Winona Mo Date signed

171 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 104/2020
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~~ Mey, Registered Apprentice No. 301 working under my personal supervision.

Signed John F. Smeaw

Licensed Embalmer No. 2516

P. O. Address Mountain View

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
8-21-41
X29288

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. 32736

Registration District No. 824 Primary Registration District No. 6076 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Shannon
(b) City or town: Eminence
(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 years, months or days)
In this community

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: George W. Custer
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: W
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 76 Months Days If less than one day hr. min.

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

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9 year 1941 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 date and hour stated above.

Immediate cause of death: Concussion due to accidental fall from porch at his home.
Due to
Due to
Other conditions (Include pregnancy within 3 months of death): 1860
Major findings: Of operations: 14
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): Accident
(b) Date of occurrence: Sept 9-1941
(c) Where did injury occur? Eminence (City or town) Shannon (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Chest house on farm (Specify type of place)
While at work? No (e) Means of injury: Accidental Fall

23. Signature: H. D. Rollins (M.D. or other)
Address: Winona Mo Date signed 11/14-41