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5-17-39
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3407

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 30 1942

Registration District No. 174

Primary Registration District No. 6018B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Esther
(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 Missouri (b) County St. Francois

(c) City or town Esther
(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.

3. (a) PRINT FULL NAME William B. Waters

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15
year 1941 hour 9 minute AM.

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

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

7. Birth date of deceased Sept. 8 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 10 1941 to Dec 15 1941; that I last saw him alive on 12-13 1941 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>3</u>	<u>7</u>	hr. _____ min. _____

Immediate cause of death Myelogenous Leukemia Duration week

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

10. Usual occupation Common Laborer

Other conditions Chylocholitis & cystitis
(Include pregnancy within 6 months of death)

Major findings: None

Of operations _____

Of autopsy 13 ft

11. Industry or business _____

12. Name Edmond Waters

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

14. Maiden name Jane Smith

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Edmond Waters

(b) Address Festus, Mo.

17. (a) _____ (b) Date thereof Dec. 17, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bismarck

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? _____

18. (a) Signature of funeral director C. Z. Boyer

(b) Address DeLoget, Mo.

19. (a) Dec. 16 1941 (b) W. B. Blackworth
(Date received local registrar) (Registrar's signature)

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

23. Signature W. B. Blackworth (M. D. or other) _____
Address _____ Date signed 12-15-41

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

400

RECEIVED

District Health Officer No. 4
District File Number 142-58
Date Filed 1-13-42

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 C. Z. Bauer

Licensed Embalmer No. 11671

P. O. Address Des Moines

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, fact should be so stated above.