

V. S. No. 2  
M-11-10-39  
Rev. 5-17-39  
I X21492

38340

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED DEC 11 1942

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 124

108  
0  
0

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

1. PLACE OF DEATH:  
(a) County Nelson  
(b) City or town Marion - Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp # 312  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 yrs 8 months  
(Specify whether \_\_\_\_\_)  
In this community Same  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Marion City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 932 Admoral  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years

3. (a) PRINT FULL NAME Joe Curcison  
(b) If veteran, name war None (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 20  
year 1942 hour 5 minute 50 A.M.  
21. I hereby certify that I attended the deceased from Nov. 15, 1942, to Nov. 20, 1942  
that I last saw him alive on Nov. 19, 1942  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive \_\_\_\_\_ years  
7. Birth date of deceased Dx Dx 1913  
(Month) (Day) (Year)

Immediate cause of death  
Epileptic Clouded State  
Due to Epilepsy  
Other conditions (Include pregnancy within 3 months of death) gs

8. AGE: Years 29 Months Dx Days Dx If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Marion City Mo. U.S.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Monday  
11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Dx Dx  
13. Birthplace Dx 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Curcison  
15. Birthplace Dx 9  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
(a) Means of injury \_\_\_\_\_  
23. Signature Wm J. Crane (M. D. or other) \_\_\_\_\_  
Address Marion Date signed 11-20-42

16. (a) Informant Wesley Reed  
(b) Address \_\_\_\_\_  
17. (a) Burial (b) Date thereof 11/23/42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt St Marys Cem  
18. (a) Signature of funeral director Roberto Farnesal  
(b) Address R.P. Mo.  
19. (a) NOV. 20, 1942 (b) Elizabeth Breckenridge  
(Date received local registrar) (Registrar's signature)

REC'D 12-9-42

RECEIVED

District Health Officer No. 7,

District File Number 12-42-1319

Date Filed 12-9-42

**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 Ray E. Snow

Licensed Embalmer No. 2560

P. O. Address Linnwood at Olive

**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.