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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6150

State File No. _____

Registration District No. 21 822

Primary Registration District No. 4144

Registrar's No. 21

I. PLACE OF DEATH:

(a) County Cooper

(b) City or town Pilot Grove
(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 None
(Specify whether years, months or days)

In this community 55 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

(c) City or town Pilot Grove, 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.? 0 years.

3. (a) PRINT FULL NAME WILLIAM-HENRY-DECK

(b) If veteran, name war no

8. (c) Social Security No. 496164972

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23 year 1943 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Feb 19, 1943, to Feb, 23, 1943; that I last saw him alive on Feb, 23, 1943; and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W.

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

6. (b) Name of husband or wife Marie Deck

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Aug 1-1887
(Month) (Day) (Year)

Immediate cause of death Acute Nephritis ✓

Duration 6 wks(?)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>6</u>	<u>22</u>	<u>✓</u> hr. <u>✓</u> min.

Due to _____

Due to _____

Other conditions Hypertension 6 mo. (?)
(Include pregnancy within 3 months of death)

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

10. Usual occupation Druggist & Banker

11. Industry or business None

MOTHER FATHER

12. Name Jacob Deck

13. Birthplace Alascedoran France
(City, town, or county) (State or foreign country)

14. Maiden name Anna Geisler

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Marie Deck

(b) Address Pilot Grove Mo

17. (a) Burial (b) Date thereof 2-26-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boonville - Walnut Grove

18. (a) Signature of funeral director Flays & Painter

(b) Address Pilot Grove, Mo

19. (a) Feb 25 43 (b) Dr Chas Swap
(Date received local registrar) (Registrar's signature)

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 G. O. Baly (M. D. or other) _____

Address Pilot Grove Date signed 2-24-43

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

RECEIVED

District Health Officer No. 8.

District File Number -----

Date Filed 3-4-43

JUL 23 1943

WILLIAM HENRY DEER
MAY 20 1943

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 Myself

-----, Registered Apprentice No. -----
working under my personal supervision.

Signed Peyton E. Hay

Licensed Embalmer No. 3074

P. O. Address Gilbert Grove,

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. 615-0

Registration District No. _____

Primary Registration District No. 4144

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Casper
(b) City or town Pilot Grove
(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 5-5 yrs
years, months or days

3. (a) PRINT FULL NAME William H. Heck

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

4. Sex m 5. Color of race or 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 5-1 years

7. Birth date of deceased Aug 1 - 1887
(Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

SUPPLEMENTARY

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

14. Maiden name _____

15. Birthplace no
(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) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State no (b) County Casper
(c) City or town Pilot Grove
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

acute nephritis

Due to Hypertension

Due to chronic nephritis

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 _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(b) 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 G. O. Bailey D (M. D. or other)

Address Pilot Grove, Mo Date signed 3-26-43

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

MOTHER FATHER

JUL 23 1943

JUN 29 1943