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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18627

Registration District No. 73

Primary Registration District No. 5913

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Perry
(b) City or town Bois Brule 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 45 years
In this community 45 years

8. (a) PRINT FULL NAME Carl C. W. Pick

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

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

6. (b) Name of husband or wife Anna Pick 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Feb. 7, 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 17 If less than one day hr. _____ min.

9. Birthplace Randolph Co., Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Grain Farming

12. Name Carl Pick

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

14. Maiden name Christina Welge

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

16. (a) Informant Herman Pick

(b) Address McBride, Mo.

17. (a) Burial (b) Date thereof May 27, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Lutheran

18. (a) Signature of funeral director Charles J. Elder
(b) Address Chester, Ill.

19. (a) May 25, 1943 (b) Thos J Elder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry
(c) City or town Rural
(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 May day 26 year 1943 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 7, 1943 to May 24, 1943; that I last saw him alive on April 130, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death mitral Regurgitation Duration 10 yrs

Due to 92 F

Due to _____
Other conditions arterio Sclerosis 10 yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none
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) none
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? none (Specify type of place) (c) Means of injury _____

23. Signature J W Beard (M. D. or other) _____
Address Chester, Ill Date signed 5/24/43

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

RECEIVED

District Health Officer No. 4

District File Number 643-2255

Date Filed 6-4-43

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

Registration District No. 273

Primary Registration District No. 5913

Registrar's No.

1. PLACE OF DEATH:

(a) County Perry
(b) City or town Academy Twp. (Rural)
(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 45 yrs
years, months or days

3. (a) PRINT FULL NAME Carl C. H. Puck
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 M

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

7. Birth date of deceased Feb 7 1867
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days _____ If less than one day _____ min.

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

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 _____
(Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 13 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____
(Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MOTHER FATHER

S-18627

JUL 8 - 1949