

FILED JAN 6 1944

Registration District No. **316**

Primary Registration District No. **3059**

Registrar's No. **135**

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

1. PLACE OF DEATH:
 (a) County **St. Francois Co.**
 (b) City or town **Bonne Terre**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Bonne Terre Hos.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **seventy yrs**
years, months or days

3. (a) PRINT FULL NAME **Ida May Straughan**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex **F**
 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **James L. Straughan**
 6. (c) Age of husband or wife if alive **78** years
 7. Birth date of deceased **Aug 12 1865**
(Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **8**
 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business **Home Maker**
 MOTHER FATHER {
 12. Name **Henry Agnew**
 13. Birthplace **Burrton**
(City, town, or county) (State or foreign country)
 14. Maiden name **Sarah Elizabeth Agnew**
 15. Birthplace **Burrton**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Vernon Nick**
 (b) Address **Farmington, Mo.**
 17. (a) **Buried**
(Burial, cremation, or removal) (b) Date thereof **Jan 1 44**
(Month) (Day) (Year)
 (c) Place: burial or cremation **Parkview - Farmington**

18. (a) Signature of funeral director **C.H. CD Zeam**
 (b) Address **Farmington, Mo.**
 19. (a) **Dec 31-1943** (b) **Byrdia Bukhmaster**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **St. Francois**
 (c) City or town **Farmington Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **30**
 year **1943** hour **3** minute **AM**
 21. I hereby certify that I attended the deceased from **Dec 22**, 19**43** to **Dec 30**, 19**43**
 that I last saw **her** alive on **Dec 30**, 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxia followed by Labor Pneumonia of Right Lung**
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) **33A**

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)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
No
(Specify type of place) (e) Means of injury
 23. Signature **R. Applegate**
(M.D. or other)
 Address **Farmington, Mo.** Date signed **Dec 31 1943**

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

AUG 30 1948

(1234567890)

District Health Officer No. 4
District File Number 144-3106
Date Filed 1-5-44

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.....

me

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Chicoza

Licensed Embalmer No. 4084

P. O. Address Farmington, Mo.

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.