

S. No. 2
M-5-43
7. 5-17-39
P I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38367**

Registration District No. **309**

Primary Registration District No. **6047**

Registrar's No. _____

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

1. PLACE OF DEATH: **St. Charles County**

(a) County **St. Charles County**

(b) City or town **Rural ~~Carter~~**

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **none**
(Specify whether _____)

In this community **not known**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **not known** (b) County **72**

(c) City or town **rural** (If outside city or town limits, write "RURAL")

(d) Street No. **St. Charles County near Flint Hill, Mo.**
(If rural, give location)

(e) Citizen of foreign country? **don't know** (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **UNIDENTIFIED**

3. (b) If veteran, name war **don't know**

3. (c) Social Security No. **don't know**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **not known** year **1945** hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, 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 **don't know**

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

7. Birth date of deceased **don't know**
(Month) (Day) (Year)

Immediate cause of death **Mesenteric Thrombosis**

Jury's verdict

Due to _____

Due to _____

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

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

Adult man-age not known hr. _____ min. _____

Major findings: _____

Of operations _____

Of autopsy **yes-**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace **not known** (City, town, or county) (State or foreign country)

10. Usual occupation **not known**

11. Industry or business **not known**

12. Name **not known**

13. Birthplace **not known** (City, town, or county) (State or foreign country)

14. Maiden name **not known**

15. Birthplace **not known** (City, town, or county) (State or foreign country)

16. (a) Informant **Coroner** **NEW KNOWN**

(b) Address **Wentzville, Mo.**

17. (a) **Dec. 10, 1945** (Burial, cremation, or removal) (b) Date thereof **Dec. 10, 1945** (Month) (Day) (Year)

(c) Place: burial or cremation **Linn Cemetery**

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 **Wentzville, Mo.** Date signed **12-10-45**

18. (a) Signature of funeral director _____

(b) Address **Wentzville, Missouri**

19. (a) **Dec 10/45** (Date received local registrar) (b) **Herbude S. Souster** (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

681

RECEIVED

District Health Officer No. 9

District File Number

Date Filed

12-15-45

2.001 P
4-8-41
IX I

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.

Signature

Maxis Murchison

Licensed Embalmer No.

2461

P. O. Address

Wentzville, 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.

Registration District No. 305

Primary Registration District No. (6047)

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Rural (Crown)
(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)

3. (a) PRINT FULL NAME

unidentified

3. (b) If veteran, name war _____

3. Social Security No. _____

4. Sex m Color or race w

6. (a) Single, widowed, married, divorced O.K.

6. (b) Name of husband or wife _____

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

7. Birth date of deceased O.K.
(Month) (Day) (Year)

8. AGE: Years Months Days

If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county)

(State or foreign country) O.K.

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) (Mrs Jess Lewis)
(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 _____ Day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

38307