

STANDARD CERTIFICATE OF DEATH

State File No. 42797

FILED JAN 15 1946
Registration District No. 273

Primary Registration District No. 6270

Registrar's No. 72

1. PLACE OF DEATH:

(a) County White
(b) City or town Rural - Union township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Manqua #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)
In this community 19 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County White
(c) City or town Manqua Mo
(If outside city or town limits, write "RURAL")
(d) Street No. RFD #2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME William Edward Papin

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Cora E. Papin 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased June - 20 - 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 5 5 x hr. x min.

9. Birthplace French Village, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Theodore Papin
13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)
14. Maiden name Leonore Aubuchon
15. Birthplace Unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. William Papin 1

(b) Address Manqua #2 mo

17. (a) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reed Cemetery

18. (a) Signature of funeral director Tex Lanning

(b) Address Marshfield, Missouri

19. (a) 1/9/46 (b) J. McInnes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25
year 1945 hour 6 minute 35 A.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.

Immediate cause of death ✓
Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____

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 Unattended (M. D. or other) _____
Address _____ Date signed _____

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.....

Lex Lerner

Licensed Embalmer No. *3312*

P. O. Address *Marshfield, Mass.*

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. *373*

Primary Registration District No. *6270*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Webster*
(b) City or town *Rural Union Twp*
(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 *William E. Papini*
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 _____ year

7. Birth date of deceased *June 20*
(Month) (Day) (Year)

8. AGE: Years *69* Months *5* Days *mo* If less than one day hr. _____ min. _____

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

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director *For Family*
(b) Address _____
19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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 *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.
Immediate cause of death _____

Due to *Right Labor*
Roman fever
Due to _____

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)
(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 *W.F. Schmitt* (M. D. or other) *2-12-46*
Address *Wagon* Date signed _____

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

SUPPLEMENTARY

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