No. 2
-9-4-41
-17-39
X29484

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

012

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 14 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1954

State File No.

Registration District No. 4 Primary Registration District No. 5024 Registrar's No.

1. PLACE OF DEATH:

(a) County ATCHISON

(b) City or town ~~ON~~ 275 9 MILES NO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ROCKPORT
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County BATES

(c) City or town BUTLER
(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

3. (a) PRINT FULL NAME ELBERT B STURGEON

3. (b) If veteran, name was WORLD II

3. (c) Social Security No. 489-22-8301

4. Sex MALE

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased APR (Month) (Day) 1923 (Year)

8. AGE: Years 22 Months 8 Days 7 If less than one day hr. min.

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

10. Usual occupation: SOLDIER

11. Industry or business ARMY A.C

FATHER
12. Name RAY E STURGEON
13. Birthplace UNKNOWN (City, town, or county) UNKNOWN (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace " (City, town, or county) " (State or foreign country)

16. (a) Informant JOE GAINES

(b) Address ROCKPORT

17. (a) ~~REMOVAL~~ BURIAL (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Bartholomew Mortuary

(b) Address Rock Port Mo

19. (a) Jan 12-1946 (Date received local registrar) (b) Betty Crabtree (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 11 year 1946 hour 3 minute 15 P.M.

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

Immediate cause of death FRACTURE of SKULL
FRACTURE 4th CERVICAL VERB
CRUSHED CHEST, FRACTURE
Due to MANDIBLE, AND LEFT LEG

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT

(b) Date of occurrence JAN 11-1946

(c) Where did injury occur? ROCKPORT (City or town) ATCHISON (County) MO (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
9 MILES NORTH ON Hy 275
(Specify type of place)

While at work? DRIVING CAR Means of injury

23. Signature Thos F Fay DO (M. D. or other)

Address Westboro Mo Date signed 1-11-46

Coroner

4

(Licensed Embalmer's Statement on Reverse Side)

FEB 1 1946

JAN 25 1946

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. Gratz Bartholomew

Licensed Embalmer No. 3173

P. O. Address. Rock Port, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

40379 Jan

State File No.

Registration District No. 4 Primary Registration District No. 5024 Registrar's No.

1. PLACE OF DEATH:

(a) County Atchison

(b) City or town Polk 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 years, months or days)

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

3. (a) PRINT FULL NAME Elbert B Sturgeon

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 Not Known

6. (b) Name of husband or wife Not Known

6. (c) Age of husband or wife if alive Not Known

7. Birth date of deceased Apr (Month) (Day) 1922 (Year)

8. AGE: Years 22 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) NO (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-46 (Month) (Day) (Year)

(c) Place: burial or cremation Butler Mo

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan Day 61
year 1946 hour minute M.

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

Immediate cause of death — Duration

Accident occurred on U.S.

Due to Hiway 275 - 9 miles North of Rock Port, State maintained hiway,

Due to He hit a bridge abutment either having gone to sleep or suffered an attack of some kind

Other conditions
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations

Of autopsy 170c-8 2M

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?
(Specify type of place)

While at work? (e) Means of injury L

23. Signature Thos Fay DO (~~M.D.~~ or other)

Address Date signed 1-16-46

SUPPLEMENTARY

012

1954