

S. No. 2
1-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5918

FILED FEB 24 1947

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 35

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Hospital No. 4 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 mos. 20 das.
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau 94

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

(d) Street No. Cape Girardeau County Farm
(If rural, give location)

(e) Citizen of foreign country? Unknown (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME FRED DEIMUND

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10
year 1947 hour 8 minute 50 A. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years
About 1862

7. Birth date of deceased _____
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 21, 1946, 19____, to Jan. 10, 1947, 19____; that I last saw him alive on Jan. 10, 1947, 19____; and that death occurred on the date and hour stated above.

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

About 8 1/2 hr. _____ min.

Immediate cause of death Interoclema

Due to _____

Due to _____

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

10. Usual occupation Farming

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

Major findings: Of operations 97

Of autopsy No autopsy.

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 1-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cem., Jackson, Mo.

18. (a) Signature of funeral director S. C. Cracraft
Jackson, Missouri

(b) Address _____

19. (a) 2-11-47 (b) Either Rudloff
(Date received local registrar) (Registrar's signature)

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) Means of injury _____

23. Signature George H. Reed (M. D. or other) M.D.
Address Farmington Mo. Date signed 1-14-47

259 (Licensed Embalmer's Statement on Reverse Side)

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

14
50

RECEIVED

Health Officer No. 4

File Number 242-256

2-21-47

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 *Gene C. Crawford*

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.