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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34954

State File No. _____

Registration District No. 382

Primary Registration District No. 5655

Registrar's No. 153

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 62 days
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94

(c) City or town Desloge
(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 Walter Rentfro

3. (b) If veteran, name war No

3. (c) Social Security No. 490-03-2706

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th
year 1947 hour 2:15 minute A M.

21. I hereby certify that I attended the deceased from July 8th, 1947, to Sept. 8, 1947
that I last saw h. in alive on Sept. 8, 1947
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 Widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: June 27 1877
(Month) (Day) (Year)

Immediate cause of death _____
Right Superior pulmonary sulcus malignancy,
Type not yet determined. Probably
Abt. 5 mos.

Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>2</u>	<u>12</u>	hr. _____ min. _____

Due to _____

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

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

10. Usual occupation Machine Shop Helper

Major findings: _____

Of operations _____

Of autopsy Same as above.

PHYSICIAN _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

MOTHER FATHER

11. Industry or business _____

12. Name William Rentfro

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

14. Maiden name Martha Mansfield

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

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? _____

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof 9-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Desloge Mo. Society Funeral Home

18. (a) Signature of funeral director W. J. ...

(b) Address Mt. Vernon, Mo.

19. (a) 1947/47 (b) W. J. ...
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature W. J. ... (M. D. or other) _____

Address Mount Vernon, Missouri Date signed 9-8-47

RECEIVED
District Health Officer No. 6,
District File Number 1047-1047
Date Filed OCT 19 1947

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. 4252

working under my personal supervision.

Signed..... *Mar. L. Joubert*

Licensed Embalmer No. 4252

P. O. Address *West, Vernon*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1102
Registrar's No. 153

Registration District No. 383 Primary Registration District No. 5655

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town St. Vrain
(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 Water Rentfro
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: June 27 (Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 10 (If less than one day) chr. _____ min. _____

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

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) _____ (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 _____ year 1947 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: (Origin) Lung (right) epidermoid carcinoma, Grade III. Duration _____

Due to _____
Due to _____

Other conditions: _____ (Include pregnancy within 3 months of death) 470

Major findings: Lung (Right) (Origin)
Of operations: Autopsy: Epidermoid carcinoma, Grade III Bone, ribs, Epidermoid carcinoma, Grade 3, invasive.
Of autopsy: Bone, vertebrae, Epidermoid carcinoma, Grade 3, invasive, Adrenal, Epidermoid carcinoma, Grade 3, meta-static.

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 Ray W. Nickman (M. D. or other) 10-27-47
Address 727 S. State Date signed _____

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

SUPPLEMENTARY

S-34954