

1938 JAN 11 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

44394  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773  
 (b) Township St. Francois Primary Registration District No. 6015A  
 (c) City Farmington Near Farmington (d) Street No. State Hwy No. 9 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME T. J. Carneal - State Hospital No. 4

(a) Residence, No. Doniphan, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
81 (?) ? ?

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT State Hospital No. 4 Records  
 (ADDRESS) Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Doniphan, Mo. DATE 12-23-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Coz Can's Farmington, Mo.  
Gar. den 5 - Doniphan, Mo.

20. FILED Dec 22, 1938 B. J. Robinson  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-22-1938

22. I HEREBY CERTIFY, That I attended deceased from 12-20-38 to 12-22-38

I last saw him alive on 12-20-38, 1938. Death is said to have occurred on the date stated above, at 1:42 am

The principal cause of death and related causes of importance were as follows:

Senility - 40 year  
exacerbation from  
psychotic excitement  
 Date of onset 2 yrs

Other contributory causes of importance:

Diabet. Insipidus heredit. yrs  
Unk. art. sclerosis  
Dehydration & weakness  
Chronic uric acid & uric acid  
 Name of operation None Date of None  
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? None Date of injury None, 1938

Where did injury occur? None (Specify city, town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None  
 Nature of injury None

24. Was disease of injury if any was related to occupation of deceased?  
 If so, specify None  
 (Signed) C. T. Vids Graves, Jr., M. D.  
 (Address) State Hospital No. 4  
Farmington, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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, \_\_\_\_\_

*C. H. Cozean*

or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

*C. H. Cozean*

Licensed Embalmer No. \_\_\_\_\_

*4084*

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

44894  
Do not use this space.

1. PLACE OF DEATH ST Francisco

(a) County ..... Registration District No. 773

(b) Township " ..... Primary Registration District No. 6018a Registered No. 172

(c) City ..... (d) Street No. .... St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME T. J. Carmel State Hosp # 4

(a) Residence, No. .... St. Mo (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m

4. COLOR OR RACE w

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 81

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS) Mch 25-39 B. J. Robinson

20. FILED Mch 25-39 B. J. Robinson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-22-1938

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... I last saw him alive on 19... Death is said to have occurred on the date stated above, at...m. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19... Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify (Signed) G. H. Shaver, M. D. (Address) State Hosp # 4

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

