

RECEIVED

District Health Officer No.

District File Number 39-1

Date Filed 2-7-39

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.....

Licensed Embalmer No.

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

3395
Do not use this space.

1. PLACE OF DEATH
 (a) County Jemise Registration District No. 605-1
 (b) Township..... Primary Registration District No. 5862 Registered No. 11
 (c) City..... (d) Street No..... 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 R. B. Lucas
 (a) Residence, No. n-m. o. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
 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. 22
 OCCUPATION
 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.....
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED March 16, 1939 Ada Martin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-22, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19....., 19.....
 I last saw h..... 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) J. R. Pinner, M. D.
Caruthersville (Address) Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED BY THE REGISTRAR. LAW. MOORE

