

REC'D MAY 22 1939

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

15443
Do not use this space.

1. PLACE OF DEATH

(a) County MACON
(b) Township
(c) City BEVIER
(e) Length of residence in city or town where death occurred

Registration District No. 527
Primary Registration District No. 5703
(d) Street No. 4312

Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St.

(f) How long in U. S., if of foreign birth? yrs. mos. ds. yrs. mos. ds.

2. PRINT FULL NAME

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

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 MARY AMEDEI
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY-23-1865
7. AGE YEARS 73 MONTHS 9 DAYS 26 If LESS than 1 day, _____ hrs. or _____ min.
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. MINER.
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) ITALY.

FATHER 13. NAME Hemonis Amedei.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ITALY.

MOTHER 15. MAIDEN NAME ROSE BERT.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ITALY.

17. INFORMANT (ADDRESS) W/A AMEDEI.
BEVIER.

18. BURIAL, CREMATION, OR REMOVAL PLACE ST. CHARLES DATE MARCH 21 1939

19. FUNERAL DIRECTOR (ADDRESS) DR. J. Edwards
Lawrence Inc

20. FILED April 29 1939 Edw. Simpson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MARCH 19 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 8 P. m.
The principal cause of death and related causes of importance were as follows:

malignancy upper abdomen producing obstructive jaundice
Type and location undetermined
Date of onset about July 1938

Other contributory causes of importance:

Name of operation _____ Date of _____
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? _____ 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. J. Honnery M. D.
MACON MO
470 (Address)

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.

53
RECEIVED

District Health Officer No. 10

District File Number 10-34-850

Date Filed MAY 12 1939

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

15-443
Do not use this space.

1. PLACE OF DEATH

(a) County macon Registration District No. 327
(b) Township _____ Primary Registration District No. 4313
(c) City Beaver (d) Street No. _____ Registered No. _____
(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

(a) Residence, No. _____ 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE YEARS <u>73</u>	MONTHS <u>9</u>	DAYS <u>26</u>
If LESS than 1 day, _____ hrs. or _____ min.		
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	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
	13. NAME	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
	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 _____ 19____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 19 1939

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:

maligancy upper ab-
domen producing ob-
structive jaundice type
of cancer of
probable gall-bladder

Name of operation _____ Date of _____

What test confirmed diagnosis? H² 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) L. P. Gronaway, M. D.

(Address) macon, mo

Local Registrar

N. B.—Every item of information should be carefully secured. It 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.

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

