

REC'D JUN 14 1939

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

19665
Do not use this space.

1. PLACE OF DEATH

(a) County..... St. Francois 1 Registration District No. 773
 (b) Township..... St. Francois Primary Registration District No. 6018A
 (c) City..... Near Farmington (d) Street No. State Hospital No. 4 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME 520 Charles Monicke

(a) Residence, No. St. Louis Co., 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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-17-1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 8 21

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor work
 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) Jefferson Barracks, D
 (STATE OR COUNTRY) Missouri

FATHER 13. NAME Henry Monicke

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

MOTHER 15. MAIDEN NAME Catherine ?

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

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

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospt. #4 Cemetery DATE 5-9 1939

19. FUNERAL DIRECTOR (NAME) Chas. Richardson
 (ADDRESS) Farmington, Mo.

20. FILED May 9 1939 T. J. Robinson (Address) Farmington, Mo.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-8 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1938, to 5-8, 1939

I last saw him alive on 5-7, 1939. Death is said to have occurred on the date stated above, at 2:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral arteriosclerosis Date of onset 1932

Concussion 7 brain 4-29-39

Other contributory causes of importance: 180 lbs
Laceration 7 occipital scalp. 4-29-39

Name of operation _____ Date of _____
 What test confirmed diagnosis? Lab. & Clin Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? homicide Date of injury 4-29, 1939

Where did injury occur? on long ward
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury as per report
 Nature of injury skipped and fell
Concussion & laceration scalp.

24. Was disease or injury in any way related to occupation of deceased? Yes
 If so, specify _____
 (Signed) Paul J. Schudum M. D.

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Chas. Richardson*

Licensed Embalmer No. *3167*

P. O. Address..... *Hamington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.