

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

41019

Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan Registration District No. 853
 (b) Township Lecky Primary Registration District No. 4519
 (c) City Newtown (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

Registered No. 22

2. PRINT FULL NAME

Benjamin Michael
 (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 M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dora Michael
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar-14-1883
 7. AGE YEARS 56 MONTHS 7 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Carpenter
 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) Murcer (STATE OR COUNTRY) Mo.

FATHER 13. NAME Joseph Michael

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

MOTHER 15. MAIDEN NAME Samantha McCuen

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

17. INFORMANT Mrs. J.W. Ham (ADDRESS) Newtown

18. BURIAL, CREMATION, OR REMOVAL PLACE Harris DATE 10-17 1939

19. FUNERAL DIRECTOR (NAME) Judd & Payne (ADDRESS) Newtown

20. FILED 14-17 1939 Mrs. Ruth Tucker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 16 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1939, to Oct 16 1939
 I last saw him alive on Oct 16 1939. Death is said to have occurred on the date stated above, at 2:30 pm.
 The principal cause of death and related causes of importance were as follows:

Chronic pleuro pulmonary carcinoma
Branchial type

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: _____, 1939

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? no
 If so, specify _____

(Signed) Y.A. Dale M.D. M. D.

(Address) Newtown, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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RECEIVED

District Health Officer No. 10

District File Number 12-39-2156

Date Filed DEC 11 1939

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.