

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.

JAN 10 1940
Registration District No. 40

Primary Registration District No. 5-616

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Elkhedge
(c) Name of hospital or institution: _____
(If not in hospital or institution, write "RURAL" and name of township) 2
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME WM M. STATEN 335
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWER
6. (b) Name of husband or wife NOT KNOWN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased not 30-1849
(Month) (Day) (Year)

8. AGE: Years 90 Months 2 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)

10. Usual occupation WAS A CARPENTER

11. Industry or business _____

MOTHER FATHER { 12. Name not known

18. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name not known
(City, town, or county) (State or foreign country)

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William W. Stateman

(b) Address Elkhedge Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parishville Mo.

18. (a) Signature of funeral director Polmann

(b) Address Sebanon Mo. 4016

19. (a) _____ (b) Nura Cole
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State ELDRIDGE (b) County LACLEDE
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 22 year 1939 hour 7 minute 20 P.M.

21. I hereby certify that I attended the deceased from DEC 18, 1939, to DEC 22, 1939 that I last saw him alive on DEC 22, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 4-5 days

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. A. Hamilton (M. D. or other) 1

Address Sebanon, Mo. Date signed 2-26-39

RECEIVED
District Health Officer No. 7
District File Number 7-40-41
Date Filed 1-9-40

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.