

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3179
Registrar's No. 5

FILED FEB 20 1940

Registration District No. 563

Primary Registration District No. 6803

1. PLACE OF DEATH: New Madrid
(a) County New Madrid
(b) City or town St. John Rural
(c) Name of hospital or institution: 2
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 3 days
In this community 50 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Mississippi
(c) City or town Rural
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME HERMAN BAIN JR.
3. (b) If veteran, name war ✓ 3. (c) Social Security No. 2

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 7, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace New Madrid Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name John Herman Bain
13. Birthplace Genoa
14. Maiden name Lillie McMyrtle
15. Birthplace Genoa

16. (a) Informant's own signature John Herman Bain
(b) Address Mathews, Mo
17. (a) Rural (b) Date thereof Jan 10, 1940
(c) Place: burial or cremation Oswood
18. (a) Signature of funeral director Wm. J. Shelly
(b) Address East Russell, Mo
19. (a) Jan 11-19-40 (b) Wm. J. Shelly
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 10 day Jan
year 1940 hour _____ min. _____ M.
21. I hereby certify that I attended the deceased from Jan 7
_____ 1940 to Jan 10, 1940
that I last saw h. aw alive on Jan 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage
Due to _____
Due to Birth Def.
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(a) Means of injury 160 ft
23. Signature W. J. Shelly (M. D. or other) _____
Address East Russell, Mo Date signed _____

RECEIVED

District Health Officer No

District File Number 240-6

Date Filed 2/19/40

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.