

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
 DEPT. HEALTH 12 1940

 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

 State File No. 8021
 Registrar's No. 50

 Registration District No. 273

 Primary Registration District No. 6018A

1. PLACE OF DEATH:

 (a) County St. Francois
 (b) City or town Near Farmington
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
State Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 11 months 27 days
 (Specify whether
 In this community
 years, months or days)

 3. (a) PRINT FULL NAME Charles S. Loback

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

 4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Dead years

 7. Birth date of deceased April 7 1874
 (Month) (Day) (Year)

 8. AGE: Years Months Days If less than one day
65 10 14 hr. min.

 9. Birthplace Haves Kansas
 (City, town, or county) (State or foreign country)

 10. Usual occupation Painter and Paper hanger

11. Industry or business _____

 12. Name Van Lobach

 13. Birthplace Illinois
 (City, town, or county) (State or foreign country)

 14. Maiden name Lucinda Stewart

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

 16. (a) Informant's own signature Records of State Hospt. #1

 (b) Address Farmington, Mo.

 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1940
 (Month) (Day) (Year)

 (c) Place: burial or cremation Memorial Park Cem.

 18. (a) Signature of funeral director Haman

 (b) Address Cape Girardeau, Mo.

 19. (a) Feb 26 -40 (b) T. J. Robinson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

 (a) State Missouri (b) County Cape Girardeau
 (c) City or town Cape Girardeau
 (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 Feb. day 21
 year 1940 hour 12 minute 15 P. M.

 21. I hereby certify that I attended the deceased from
Feb. 21, 1939 to Feb. 21, 1940;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

 Immediate cause of death Cerebral hemorrhage
Marked hypertensive heart disease with
psychosis. General arteriosclerosis. Vrs. _____
 Due to Marked.

 Due to _____
 Other conditions 45 ft
 (Include pregnancy within 3 months of death)

 Major findings: no
 Of operations _____

 Of autopsy no

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? no
 (City or town) (County) (State)

 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
no

 (e) no (Specify type of place)

 (f) no (e) Means of injury _____

 23. Signature T. J. Robinson (M. D. or other) M. D.

 Address Farmington, Mo. Date signed _____

 Duration 12 hrs

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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.....

Howard L. Kaman

Licensed Embalmer No.....

4122

P. O. Address.....

Cape Girardeau

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.