DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10134

Registration District No. 1026 Primary Registration District No. 5702A Registrar's No. 7

1. PLACE OF DEATH:
(a) County Bollinger
(b) City or town Rural, Lorance
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Bollinger
(c) City or town Glen Allen, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Jacob Marion Deck 20

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eliza Jane Deck

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased April (Month) 18 (Day) 1858 (Year)

8. AGE: Years 81 Months 10 Days 21 If less than one day hr. min.

9. Birthplace Glen Allen (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Fredrick Marion Deck
13. Birthplace Glen Allen (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Eliza Jane Sites
15. Birthplace Marquand Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A D Deck
(b) Address 240 E. Wash. Kirkwood, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Glen Allen

18. (a) Signature of funeral director Baker Funeral Home
(b) Address Lutesville, Mo.

19. (a) Apr. 8-1940 (Date received local registrar) (b) Mrs. Willie H. VanDanburgh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th year 1940 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from Mar 4 1940 to Mar 8 1940 that I last saw h[illegible] alive on Mar 8 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Influenza 6/ 11 D	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature A D Deck (M. D. or other)
Address Lutesville Date signed 4/13/40

(Licensed Embalmer's Statement on Reverse Side)

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.

30M-5-17-39
Rev. 5-17-39
1 X19911

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.....

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

working under my personal supervision.

Signed Thomas E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, Mo.

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.

S. No. 2B
M—2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7 10134

Registration District No. 1026

Primary Registration District No. 3102A

Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Laradee Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(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.

3. (a) PRINT FULL NAME Jewel Marion Deer
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 M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 81 | Months 10 | Days 21 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Edna Jane Biles
15. Birthplace Marquand (City, town, or county) Mo. (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Apr 8 1940 (Date received local registrar) (b) Willie H. VanAmburgh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 9
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature N. D. Sample (M. D. or other)
Address Leadville Date signed

SUPPLEMENTARY

S-10134 - 1940