DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11245

Registration District No. 400 Primary Registration District No. 5333B Registrar's No. 36

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Prairie township. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 months 16 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Jackson County Home (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 JOHN PASNEU 257

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 widower

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Unknown (Month) (Day) 1880 (Year)

8. AGE: Years 60 Months Unknown Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Unknown

FATHER 12. Name Unknown

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

MOTHER 14. Maiden name Unknown

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

16. (a) Informant's own signature Ernest Jackson

(b) Address Little Blue Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-21-40 (Month) (Day) (Year)

(c) Place: burial or cremation Kirkwood Co of Ost

18. (a) Signature of funeral director [illegible]

(b) Address [illegible]

19. (a) 3/7/40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19 year 1940 hour 7. minute P. M.

21. I hereby certify that I attended the deceased from 2-1, 1940 to 2/18, 1940; that I last saw h. alive on 2/18, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis catheter

Due to

Due to 42

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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 J. W. Greene (M. D. or other)

Address J. Schifenbauer Date signed 2/21/40

(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.

Rev. 5-17-39 1 X19311

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.....3991.....

P. O. Address.....5725 Virginia

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.