

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11406

Registration District No. 421

Primary Registration District No. 55750

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Jefferson  
(b) City or town Crystal City  
(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)

8. (a) PRINT FULL NAME Barbara Ellen Day  
3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2 24 1865  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Unknown Boyer  
13. Birthplace "  
(City, town, or county) (State or foreign country)  
14. Maiden name Susan Hewitt  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Bennett  
(b) Address Crystal City, Mo

17. (a) Burial (b) Date thereof 3 10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Methodist Cem.

18. (a) Signature of funeral director E. L. Fink  
(b) Address Festus Mo

19. (a) 3/12/40 (b) J. E. Rutledge MW  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Crystal City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 218 Pine St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 8  
year 1940 hour 10 - minute - A. M.

21. I hereby certify that I attended the deceased from March 6  
1940, to March 8, 1940  
that I last saw her alive on March 8, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage -  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

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 \_\_\_\_\_  
(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? 345  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Bertalan Bolgan (M. D. or other) 1  
Address Festus, Mo Date signed 3/19/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

I 18931

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address Festus 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.**