

APR 23 1940

Registration District No. 23

Primary Registration District No. 6024 B

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Leadwood
(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 11/2

3. (a) PRINT FULL NAME

EARL LEE STAPLES

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 5

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 1939 years

7. Birth date of deceased March 9/23
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
	<u>5</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace

Leadwood Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Larry E. Staples
13. Birthplace Leadwood Mo
(City, town, or county) (State or foreign country)
14. Maiden name Thelma Jinson
15. Birthplace Leadwood Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Larry E. Staples
(b) Address Leadwood Mo
17. (a) Grand Clay Mo (b) Date thereof Mar 15-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Grand Clay Mo.
18. (a) Signature of funeral director B. Boyer
(b) Address Leadwood Mo
19. (a) 4-10-1940 (b) W. E. Dubuichon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois
(c) City or town Leadwood Mo
(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 March day 13
year 1940 hour 9 minute 45 M.

21. I hereby certify that I attended the deceased from 2-13-
1940, to 3-13- 1940

that I last saw him alive on 3-13- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Double Broncho Pneumonia
Due to _____
Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

1 Day

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J. W. Gale (M. D. or other) _____
Address Leadwood Mo Date signed 3-11-40

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.

107W

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17756
Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 33

Primary Registration District No. 6024 B

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

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Randolph sur
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Earl Lee Staples

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 8

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

Months

Days

If less than one day

5

20

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar)

(Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mh day 13
year _____ hour _____ minute _____ M.

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

Immediate cause of death Double Bronchitis

Pneumonia

Due to Messesel

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature F. W. Gale (M. D. or other) _____

Address Bismarck Date signed me

SUPPLEMENTARY

1940
S-12256