

APR 23 1940

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 73

1. PLACE OF DEATH:

(a) County St. Francois

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

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

(d) Length of stay: In hospital or institution about 5 weeks
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Flat River
(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 JANE LUELLA GRINDELL

3. (b) If veteran, name war L

3. (c) Social Security No. ✓

4. Sex F

5. Color or race White

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

6. (b) Name of husband or wife Frank

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

7. Birth date of deceased Nov. 7 1859
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>4</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name William Hayes

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

14. Maiden name Jane Rank

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

16. (a) Informant's own signature Mrs. W. A. McArrow

(b) Address Flat River, Mo

17. (a) Burial (b) Date thereof Nov. 2 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hof Englund, France

18. (a) Signature of funeral director Jas. Decker

(b) Address Flat River, Mo

19. (a) Apr 2 1940 (b) T. J. Robinson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st
year 1940 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from Mar. 31-1940
1940 to Mar. 31 1940
that I last saw her alive on Mar. 31-1940, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral haemorrhage, apoplexy Duration 8 to 10 hrs.

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? _____

While at work? _____ (Specify type of place)

(c) Month of injury _____

23. Signature R. B. Pester M.D. (Dr. or other) _____

Address Deerloge Mo. Date signed 4/1/40

WRITE FULLY—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.

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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 C. J. Claywell

Licensed Embalmer No. 3706

P. O. Address Bonne Terre, 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.