

Registration District No. 421

Primary Registration District No. 5375A

Registrar's No. 42

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 _____ (Specify whether _____)

In this community _____ years, months or days (3/1/40)

8. (a) PRINT FULL NAME Eunice A. Axley

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Joseph W. Axley 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 9 1853
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Noah Eymann 9

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Mrs. Floyd Kerkoski

(b) Address Crystal City Mo.

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

(c) Place: burial or cremation Scouters, Ill.

18. (a) Signature of funeral director E. L. Frink

(b) Address Festus Mo.

19. (a) 4-15-1940 (b) J. E. Rullage Mo.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

(c) City or town 206 Broadway
(If outside city or town limits, write "RURAL")

(d) Street No. Crystal City
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 13
year 1940 hour _____ minute 10:30 P. M.

21. I hereby certify that I attended the deceased from Feb 1 -
1940, to Apr 13 - 1940
that I last saw her alive on Apr 13 - 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration! _____

Due to Supernatural of old age

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? _____

382 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature J. H. ... (M. D. or other) _____

Address Crystal City Mo. Date signed 4-14-40

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 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15214

Registrar's No. 42

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 421

Primary Registration District No. 5573a

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

1. PLACE OF DEATH

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

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

Funice A Apley

(b) If veteran, name war (c) Social Security No.

4. Sex 7 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 year

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

8. AGE: Years 86 Months 4 Days 4 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 FATHER { 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) (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) (Date received local registrar) (b) (Registrar's signature)

PHYSICIAN CERTIFICATION

20. DATE OF DEATH Month 4 day 13 year 1940 hour minute M.

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

Immediate cause of death: Hypostatic Pneu - Bronchial Inflammation of old age

Due to 1072

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) Means of injury

23. Signature J. F. Donnell (M. D. or other) Address Crystal City Mo date signed

SUPPLEMENTARY

