

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

15958

Registration District No.

774

Primary Registration District No.

4465

Registrar's No.

943

1. PLACE OF DEATH:

(a) County ST. FRANCOIS
 (b) City or town FLAT RIVER
 (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 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 ADOLPH A MEADOR 360

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MAUDE BOLLINGER 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased DEC 2 1878
 (Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace WARRAR COUNTY MOO
 (City, town, or county) (State or foreign country)

10. Usual occupation DOCTOR OF MEDICINE

11. Industry Practising Physician

MOTHER FATHER { 12. Name JAMES MEADOR

18. Birthplace TENNESSEE
 (City, town, or county) (State or foreign country)

14. Maiden name ANNA BOLLINGER
 (City, town, or county) (State or foreign country)

15. Birthplace DON'T KNOW
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Maude Meador

(b) Address FLAT RIVER

17. (a) BURIAL (b) Date thereof April 21 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Memorial park

18. (a) Signature of funeral director C. J. Doyen

(b) Address DESLAGE MO 617

19. (a) 4-18-40 (b) G. Starnes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
 year 1940 hour 11.20 minute P PM.

21. I hereby certify that I attended the deceased from Dec. 18th
1939 to Apr. 17th 1940
 that I last saw him alive on April 17th 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Myelogenous leukemia Duration unknown

Due to _____

Due to _____

Other conditions none
 (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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. J. Marselle (M.D. or other) MD

Address Flat River, Mo. Date signed 4-20-40

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.

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 E. G. Boyer.
Licensed Embalmer No. 1671
P. O. Address Desloge, 4/110

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.