

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15982
Registrar's No. 946

Registration District No. 774 Primary Registration District No. 6018B

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Esther mo
(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 _____ (Specify whether)
years, months or days lifetime

3. (a) PRINT FULL NAME Lucenda Frey
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 wid
6. (b) Name of husband or wife Frey 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 11 1895
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Esther mo
(City, town, or county) (State or foreign country)

10. Usual occupation House maid

11. Industry or business _____
12. Name James H Edwards
13. Birthplace Kenbuckny
(City, town, or county) (State or foreign country)
14. Maiden name Lucyada Richards
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Edwards
(b) Address Brookland

17. (a) Burial (b) Date thereof 4-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rest View

18. (a) Signature of funeral director Sparks & Son
(b) Address Esther mo

19. (a) 4/12/40 (b) C. P. Carr
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Francois
(c) City or town Esther
(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 4 day 8
year 1940 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Heart attack
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? 697
While at work? _____ (Specify type of place) (e) Means of injury Corner

23. Signature Joe Niemes (M.D. or other) Corner
Address Blat River Date signed 4.9.40

8.00 a.

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. 15982

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 774

Primary Registration District No. 60.18B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francis
(b) City or town St. Francis T.P.
(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 Lucinda Inge

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 wid

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 64 Months 5 Days 27 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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month 4 day 8
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 _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Heart attack

Due to Chronic myocarditis

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 Dr. James Cox _____ (Print name of other)

Address Flat River Mo _____ Date signed 6-15-40

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SUPPLEMENTARY

