

Registration District No. 678

Primary Registration District No. 4404

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Phelps  
(b) City or town ST JAMES  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 9  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 45 YEARS  
years, months or days

3. (a) PRINT FULL NAME FRANK PRESTINE

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 CLARA PRESTINE 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased OCT - 23 - 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Stone mason

11. Industry or business 9

12. Name not known

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's own signature Arthur Preston

(b) Address Detroit Michigan

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

(c) Place: burial or cremation St James Mo.

18. (a) Signature of funeral director J. James Roman

(b) Address St James Mo.

19. (a) 6-24-40 (b) Clara B Hawk  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps  
(c) City or town St James  
(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 June day 21<sup>st</sup>  
year 1940 hour 1 pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from March 1-40  
\_\_\_\_\_, 19\_\_\_\_, to June 21, 1940;  
that I last saw him alive on June 21<sup>st</sup>, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Hypertension 1092

Due to arterio-sclerosis "

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 9410

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy none

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?  
\_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Frank W. Kricher (M. D. or other) \_\_\_\_\_

Address St James Mo Date signed 6/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

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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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 740 743

Licensed Embalmer No.....

Date Filed 7/1/40

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.**