

SEP 19 1940
Registration District No. 266

Primary Registration District No. 5269 5347 Registrar's No. 58

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Meramec Typo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: XXXX
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX
In this community most of his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME John W. Major 260

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

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

6. (b) Name of husband or wife Elnora McGinnis 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased April 26 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 14 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name John Milton Major

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

14. Maiden name Mary Key

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

16. (a) Informant John Major
(b) Address Salem Mo

17. (a) burial (b) Date thereof 8/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem.

18. (a) Signature of funeral director Carl Spencer

(b) Address John Mc Carl K Spencer

19. (a) Aug 12 1940 (b) F. E. Smith
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Salem, Missouri - P.R.
(If rural, give location)
(e) If foreign born, how long in U. S. A. XXX years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10
year 1940 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan 2 1940
1940, to Aug 9 1940
that I last saw him alive on Aug 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate gland

Due to

Due to

Other conditions Ela Scott MD

Major findings: Of operations no

Of autopsy no

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? no (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) While at work? ✓ (e) Means of injury ✓

23. Signature Ela Scott (M. D. or other) ✓

Address St. Joseph Hospital Date signed 8/10/40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

57

RECEIVED

District Health Officer No. 5,

District File Number 940939

Date Filed _____

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 Carl K. Juncos

Licensed Embalmer No. 2870

P. O. Address Carl K. Juncos

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **28410**

Registration District No. **266**

Primary Registration District No. **5317**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Dent**
(b) City or town **Meramec 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 **John W. Major**

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 **70** Months **3** Days **14** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **10**
year **1946** 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 **Carcinoma of Prostate and Bladder**

Due to **Carcinoma of Prostate and Bladder**

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 **[Signature]** (M. D. or other) _____

Address **[Address]** Date signed _____

SUPPLEMENTARY

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

St James 720

1988