

OCT 12 1940
Registration District No. **218**

Primary Registration District No. **3015**

Registrar's No. **96**

1. PLACE OF DEATH:
(a) County **COOPER**
(b) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether
In this community **TWO DAYS**
years, months or days)

8. (a) PRINT FULL NAME **JOHN LECHTER BLACK**
3. (b) If veteran, name war **NONE** **3. (c) Social Security** No. **NONE**

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

6. (b) Name of husband or wife **NELL LUCILLE SCOTT BLACK** **6. (c) Age of husband or wife if** alive **34** years

7. Birth date of deceased **SEPT. 3** **1906**
(Month) (Day) (Year)

8. AGE: Years **34** Months **0** Days **8** If less than one day hr. min.

9. Birthplace **SALINE COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **FARM**

12. Name **SAMUEL L. BLACK**

13. Birthplace **WAYNE COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

14. Maiden name **IDA A. MARTIN**

15. Birthplace **HARRISON COUNTY KENTUCKY**
(City, town, or county) (State or foreign country)

16. (a) Informant **HOSPITAL RECORDS**

(b) Address **BOONVILLE MO.**

17. (a) BURIAL (b) Date thereof **SEPT. 13th**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **RIDGE PARK - MARSHALL**

18. (a) Signature of funeral director **STEGNER & KOENIG**

(b) Address **BOONVILLE MO.**

19. (a) 9-12-40 (b) **D. E. Hooper**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **SALINE**
(c) City or town **RURAL**
(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 **Sept** day **11**
year **1940** hour **1** minute **15 P** M.

21. I hereby certify that I attended the deceased from **9-10-40**
_____, 19____, to **9-11-40**, 19____;

that I last saw him alive on **9-11-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **cerebral hemorrhage** **12 hrs**

Due to **chronic alcoholism** **20 yrs**

Due to **?**

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

Major findings:
Of operations **none done**

Of autopsy **none done**

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? _____

23. Signature **A. L. ...** (M. D. or other)

Address **Boonville, Mo.** **Date signed** **9-11-40**

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-9-40

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 James W. Stegner
Licensed Embalmer No. 37801
P. O. Address Bonville, Md

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.