

1-10-39
17-39
X21492

STANDARD CERTIFICATE OF DEATH

State File No. _____

FULL OCT 18 1940

Registration District No. _____ Primary Registration District No. 4538 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Potosi
(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 _____ (Specify whether)
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wash
(c) City or town Potosi 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.

8. (a) PRINT FULL NAME Fabian P Dechul

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

4. Sex Mr 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mrs Dechul 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased Mar 11 1902
(Month) (Day) (Year)

8. AGE: Years 38 Months 9 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER
12. Name Steph E Dechul
13. Birthplace Washington Mo (City, town, or county) (State or foreign country)
14. Maiden name Mary Pasha
15. Birthplace Old Mission Mo (City, town, or county) (State or foreign country)

16. (a) Informant Steph Dechul
(b) Address Potosi Mo

17. (a) _____ (b) Date thereof Aug 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Potosi Mo

18. (a) Signature of funeral director Sparks
(b) Address Potosi Mo

19. (a) Oct 15-40 (b) F. Dechul
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 24 1940
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 2 -
1940 to Aug 24 1940
that I last saw him alive on Aug 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death peritonitis
Due to operation for appendix abscess
Due to _____

Other conditions (Include pregnancy within 3 months of death) 171

Major findings: Of operations _____
Of autopsy _____

Duration _____
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? 80%
While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature Joseph L. Thurman (M. D. or other) _____
Address Potosi, Mo. Date signed 9/25/40

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

W. D. ...

11/27/4
11092
13/11/84
113/54
52

13
92

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.

7 = 7
123
47

Signed _____

Licensed Embalmer No. _____

P.O. Address _____

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. **33399**

Registration District No. **887**

Primary Registration District No. **4538**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Washington**
(b) City or town **Potosi**
(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 _____ (Specify whether _____)
years, months or days **FABIAN**

3. (a) PRINT FULL NAME **Fabian P. Declue**

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 **W**

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 **38** Months **9** Days **15** If less than one day _____ 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) **Dec 1-45** (b) **G. F. Besore** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Wash**

(c) City or town **Potosi (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 **aug** day **24** 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 _____

Duration

Due to _____

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 **Jos. P. Thompson** (M.D. or other) _____

Potosi Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

