

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38406**

Registration District No. **146**

Primary Registration District No. **6208**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **CARTER Co.**
(b) City or town **Grandin**
(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 **13 years** years, months or days **2**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **CARTER**
(c) City or town **Grandin**
(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.

3. (a) PRINT FULLNAME **EMANUEL BEDARD**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

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

6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **NOVEMBER 4 1956**
(Month) (Day) (Year)

8. AGE: Years **84** Months **-** Days **17** If less than one day **-** hr. **-** min.

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

10. Usual occupation **GARDENER**

11. Industry or business **17**

12. Name **ELIAH BEDARD**

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **Dr. J. J. Langdon**

(b) Address **Grandin, Mo.**

17. (a) **BURIAL** (b) Date thereof **NOV. 22 '40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grandin Cemetery**

18. (a) Signature of funeral director **Black's Mortuary**

(b) Address **Danish, Mo.**

19. (a) **11-25-1944** (b) **Loyal E. Ward**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **21st** year **1940** hour **1** minute **AM** A.M.

21. I hereby certify that I attended the deceased from **2-1-1940 to Nov 21 1946**
that I last saw him alive on **2-1-1940** and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to **Cerebral Hemorrhage** **1-1-40**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **926**

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? **923**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Clifford J. J. J.** (M. D. or other) **1**
Address **Danish, Mo.** Date signed _____

RECEIVED
REG
District Health Officer No. 8,
District File Number 1240/203
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 _____

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, fact should be so stated above.