

Registration District No. 775

Registration District No. 620-A

Registrar's No.

278

1. PLACE OF DEATH:

- (a) County St. Francois
 (b) City or town Bonne Terre Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Bonne Terre Hospital
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 1 day (Specify whether
 In this community years, months or days) 1

3. (a) PRINT FULL NAME EARL MASTERS

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased June 9 1920
(Month) (Day) (Year)8. AGE: Years 30 Months 5 Days 16 hr. _____ min. _____9. Birthplace Glenn Allen Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Chamber

11. Industry or business _____

12. Name Manuel Masters13. Birthplace Glenn Allen Missouri
(City, town, or county) (State or foreign country)14. Maiden name Maggie Lincoln15. Birthplace Butteville Missouri
(City, town, or county) (State or foreign country)16. (a) Informant Manuel Masters(b) Address Butteville Missouri17. (a) Burial (b) Date thereof Nov 28 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Butteville Mo18. (a) Signature of medical director L. G. Baker(b) Address Butteville Mo19. (a) Nov 27 1940 (b) N. W. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25
year 1940 hour 4:15 minute _____ P. M.21. I hereby certify that I attended the deceased from 11-24 - _____, 1940, to 11-25, 1940;
that I last saw him alive on 11-25, 1940;
and that death occurred on the date and hour stated above.Immediate cause of death Skull fracture, rt. parietal area. Duration 1 da.

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) Accident(b) Date of occurrence 11-24-40(c) Where did injury occur? Highway 61, St. Francois County
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Roadside
(Specify type of place)While at work? no (e) Means of injury: Auto23. Signature H. W. Roebber (M. D. or other) MDAddress Bonne Terre, Mo Date signed 11/25/40

210 M
98

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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39631

Registration District No. 275

Primary Registration District No. 6020A

Registrar's No. 78

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Bonne Terre
(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)

3. (a) PRINT FULL NAME Earl Masters

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 S

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	Months	Days	If less than one day
	<u>20</u>	<u>5</u>	<u>16</u>	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 _____ (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. DATE OF DEATH: Month 11 day 25 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: Skull fracture at parietal area

Due to struck by a motor car while on side of road and

Due to knocked against bumper of parked car. Head struck said bumper.

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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) acc

(b) Date of occurrence 11-24-1940

(c) Where did injury occur St. Francois Co. Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway 61 - Roadside (Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature H. M. Haebler (M. D. or other) MD.

Address Bonne Terre, Mo. Date signed 1-29-41

SUPPLEMENTARY

1940

S-39631