

Registration District No. 882 Primary Registration District No. 6174 Registrar's No. 16

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Hickory Grove Rural
(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 _____

8. (a) PRINT FULL NAME MELVIN-ELIU-FRANCE

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

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

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

7. Birth date of deceased Nov 24 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name George France
13. Birthplace Lincoln Co.
(City, town, or county) (State or foreign country)
14. Maiden name Label Matheus
15. Birthplace Lincoln Co.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature George B France
(b) Address Foristell Mo

17. (a) Burial (b) Date thereof 12 7 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wentville, Mo Cen.

18. (a) Signature of funeral director Nelburg FA U. Co.
(b) Address Wright City Mo.

19. (a) 12/7/40 (b) Julius Nelburg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Warren
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Hickory Grove township
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 7
year 1940 hour _____ minute 30 M.

21. I hereby certify that I attended the deceased from Nov. 24
_____ 1940 to December 7, 1940
that I last saw him alive on December 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
trauma
Due to New Basin

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

Major findings: _____
Of operations _____
Of autopsy _____
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? _____
_____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Jul B. Hilloran (M. D. or other) _____
Address Wright City Mo Date signed 12/7/40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

851

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.

Registration District No. 882

Primary Registration District No. 6174

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County Warren

(b) City or town Hickory Grove 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 Melvin Elvin France

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M

5. Color or race negro

6. (a) Single, widowed, married, divorced.....

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

13 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 12/7/40 (Date received local registrar) (b) Julius Nieburg (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death Infarction

Due to Heart

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 John B. Kellion M. D. or other)
Address Wright City Mo Date signed.....

SUPPLY METERS

1940
0161
S-40018

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40078

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 882

Primary Registration District No. 6174

Registrar's No.

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Secretary Grove 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..... (Specify whether
years, months or days)

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.

3. (a) PRINT FULL NAME Melvin Elvin Francone

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

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

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
13 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)..... (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Dec. day 7
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.....

Transition
New born

Due to.....
Due to.....
Due to.....

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

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?

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

23. Signature Hubert S. Belloran M.D. (M. D. or other)

Address High City, Mo Date signed 1/29/41

SUPPLEMENTARY

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

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

MISSOURI STATE BOARD OF HEALTH