

APR 9 1941

Registration District No. 774

Primary Registration District No. 4865

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Flat River
(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 Anna Evelyn Nowine

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

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased Sept 16 1892
(Month) (Day) (Year)

8. AGE: Years 48 Months 5 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Rev. L. O. Nichol

18. Birthplace Cent Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Anna Bell Simmons

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

16. (a) Informant B. E. Nowine

(b) Address Flat River Mo

17. (a) Burial (b) Date thereof 3-12-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre Cemetery

18. (a) Signature of funeral director Baldwell

(b) Address Flat River Mo

19. (a) 3-15-41 (b) B. E. Nowine
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED

(a) State Mo (b) County St. Francois

(c) City or town Flat River
(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 March day 11
year 1941 hour 5 minute 5 M.

21. I hereby certify that I attended the deceased from Dec 4 1929 to March 11 1941
that I last saw her alive on March 10 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Anuricemia Duration _____

Due to Hypertension

Due to _____

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

Major findings of operations _____

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)

Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature [Signature] (M. D. or other) [Signature]

Address Flat River Mo Date signed 3.10.41

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

5-17-39
I X21492

74
5
2

94
5
2

PHYSICIAN

Underline the cause to which death should be charged statistically.

96

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11894

Registration District No. 774

Primary Registration District No. 4465

Registrar's No. _____

1. PLACE OF DEATH

(a) County St. Francois
 (b) City or town Flat River
 (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

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 _____

3. (a) PRINT FULL NAME Anna Evelyn Nowine
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Mar day 11
 year _____ hour _____ minute _____ M.

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

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
 that I saw him _____ alive on _____ 19____
 and that death occurred on the date and year stated above.

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

Immediate cause of death Aortic Aneurysm Duration _____
Hypertension

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

Due to Not due to Syphilis.

8. AGE: Years 48 Months 5 Days 25 If less than one day _____ hr. _____ min.

Due to deceased had 5 negative tests by 3 different laboratories also negative spinal fluid.

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

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

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

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

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

14. Maiden name _____ (State or foreign country) _____

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

16. (a) Informant _____ (b) Address _____

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 _____

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

SUPPLEMENTAL

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

MOTHER FATHER

11894