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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

MAY 26 1941 STANDARD CERTIFICATE OF DEATH

State File No. 16029

Registration District No. 924

Primary Registration District No. 6071

Registrar's No.

1. PLACE OF DEATH

(a) County Shannon  
(b) City or town 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon  
(c) City or town 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. 0 years.

3. (a) PRINT FULL NAME Marjorie French

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

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

6. (b) Name of husband or wife Norris French 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May 1 - 1914  
(Month) (Day) (Year)

8. AGE: Years 26 Months 10 Days 24 If less than one day hr. min.

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

10. Usual occupation But

11. Industry or business

12. Name Frank Cooley

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

14. Maiden name Nora Rogers

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

16. (a) Informant Norris French

(b) Address Quincy Mo

17. (a) Burial (b) Date thereof Mar 25 - 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mummell Chapel

18. (a) Signature of funeral director Deaneau

(b) Address 117 West MO

19. (a) 3-23-41 (b) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 25 year 1941 hour 2 minute 50 P M.

21. I hereby certify that I attended the deceased from Jan 1 - 4 Mar 25, 1941, to Mar 25, 1941; that I last saw him alive on Mar 25, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to 12/21

Other conditions (Include pregnancy within 3 months of death)

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?

23. Signature Frank Cooley (M. D. or other) MD  
Address Quincy Date signed 3-25-41

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

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RECEIVED

District Health Officer No 5,

District File Number 5411663

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 John J. Amicini

Licensed Embalmer No. 2516

P. O. Address 125 West 9th St

**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

Registration District No. 824

Primary Registration District No. 6076

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Commerce 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)

2. (a) PRINT FULL NAME Margorie French  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 26 Months 10 Days 24 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 2-25-41 (b) Frank Hyde md.  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Mar day 26 -  
year \_\_\_\_\_ 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 Frank Hyde (M. D. or other) \_\_\_\_\_

Address Commerce Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

