

Registration District No. 470

Primary Registration District No. 15633

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mt Vernon
(c) Name of hospital or institution: Mo State San
(d) Length of stay: In hospital or institution 192 days
In this community 192 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jefferson
(c) City or town Crystal City
(d) Street No. 405 Niagara
(e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME Frances Marie DePousse

3. (b) If veteran, name war No
3. (c) Social Security No. 492-12-0264

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept 24 1919
(Month) (Day) (Year)

8. AGE: Years 21 Months 7 Days 26
If less than one day hr. min.

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

10. Usual occupation Factory worker

11. Industry or business Glass Works

12. Name Alons DePousse

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

14. Maiden name Ida Boyer

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

16. (a) Informant Mrs. Michael Record

(b) Address Mo State San

17. (a) Date of death May 21 1941
(b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Crystal City

18. (a) Signature of funeral director R. A. Holmes
(b) Address Crystal City Mo

19. (a) Date received local registrar May 21 1941
(b) Registrar's signature R. A. Holmes

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 20th year 1941 hour 3:30 minute P.M.
21. I hereby certify that I attended the deceased from May 19 to May 20 1941
that I last saw her alive on May 20 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
Duration 1 yr

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 (M. D. or other) Date signed 5/20/41

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

MOTHER FATHER

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

JUN 25 1941

RECEIVED

District Health Officer No. 6,

District File Number 641-884

Date Filed JUN 6 1941

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.....

Geordie R. Politt

Licensed Embalmer No. 3481

P. O. Address Crystal City 9

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.