No. 2
-1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26056

Registr District No. 773 Primary Registration District No. 6018A Registrar's No. 116

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Near Farmington T. 1 - Ranch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 yr. 5 mo. 4 day (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot 94

(c) City or town 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charley Lester

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased (Month) (Day) 1902 (Year)

8. AGE: Years	Months	Days	If less than one day
39	Un.	Un.	hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name "
15. Birthplace " 9
(City, town, or county) (State or foreign country)

16. (a) Informant Records of State Hosp. #4

(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-41 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion Cem. Steele, Mo.

18. (a) Signature of funeral director German Undertaker Co.

(b) Address Steele, Mo.

19. (a) July 22-41 (Date received local registrar) (b) T. J. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22 year 1941 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 5-25, 1941 to 7-22, 1941; that I last saw him alive on 7-22, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Status epilepticus	30 min
Due to idiopathic epilepsy	38 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death) Mental deficiency	birth
Major findings: Of operations 47	
Of autopsy Bilateral cerebral atrophy Multiple cortical infarcts	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Paul Jochiadn (M. D. or other) MD

Address Farmington, Mo. Date signed 7-22-41

(Licensed Embalmer's Statement on Reverse Side)

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 William C Shelton

Licensed Embalmer No. 3929

P. O. Address Steele, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2605-6

Registration District No. 773 Primary Registration District No. 6018a Registrar's No. 116

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town near Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Hospital 204
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DEACESED:
(a) State Mo (b) County Ponniscot
(c) City or town unknown to registrar
(If outside city or town limits, write "RURAL")
(d) Street No. unknown to Registrar
(If rural, give location)
(e) Citizen of foreign country? not a citizen of Dist 773 (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Charley Lester
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 ..... hr. ..... 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) ..... (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) 9-22-41 (Date received local registrar) (b) T. J. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... 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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (c) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY