

No. 2
4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32468

State File No. _____

Registrar's No. 137

Registration District No. 773

Primary Registration District No. 6018A

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town St. Francois
(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 2 months, 5 days
(Specify whether years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 2233 Woodson Road
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sam J. McMinn

3. (b) If veteran, name war No 3. (c) Social Security No. 694-01-0843

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased March 1st 1904
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>37</u>	<u>6</u>	<u>29</u>	_____ hr. _____ min.

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

10. Usual occupation Bus Driver

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Joseph McMinn

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

14. Maiden name Maude Conrad

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

16. (a) Informant State Hospital No. 4 Records

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 10-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetary

18. (a) Signature of funeral director St. Charles, Missouri

(b) Address Ortmann Funeral Home

19. (a) Sept 30-41 (b) W. S. Robinson
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1941 hour 5 minute 30 a.m.

21. I hereby certify that I attended the deceased from 7-25-41
_____ 19____ to 9-30-41 19____

that I last saw him alive on 9-29-41 19____
and that death occurred on the date and hour stated above.

Immediate cause of death General paralysis of Insane
1 + yrs?

Due to with terminal progressive
degeneration of brain (Death Sudden)

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

Major findings: Of operations None

Of autopsy None

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) no

(b) Date of occurrence None

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature W. S. Robinson (Dr. or other) _____

Address _____ Date signed _____

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

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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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed J. H. Anderson
Licensed Embalmer No. 2238
P. O. Address Farmington

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.