

REC'D MAR 24 1947 91

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether
In this community 11 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Montgomery
(c) City or town Farmersville, Ill
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1
year 1942 hour 6:30 minute A. M.
21. I hereby certify that I attended the deceased from February
18th 1942, to March 1 1942.
that I last saw him alive on March 1 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis (bilateral)
Due to _____
Due to _____
Other conditions job
(Include pregnancy within 3 months of death)

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

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 John Savoy (M. D. or other) _____
Address BARNES HOSPITAL Date signed _____

3. (a) PRINT FULL NAME Roger Leo Cummerford
(b) If veteran, name war No (c) Social Security No. No

4. Sex Male 5. Color or race 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. Dec. 13 1917
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>24</u>	<u>2</u>	<u>16</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business Grain Farming

12. Name Thomas M. Cummerford

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

14. Maiden name Julia T. Clarke

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

16. (a) Informant Thomas M. Cummerford

(b) Address Farmersville Ill.

17. (a) Removal (b) Date thereof 3-3-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farmersville, Ill

18. (a) Signature of funeral director A. H. Hoppe

(b) Address 4700 Washington

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

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

MOTHER FATHER

1967

1967

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

J. Wm. Kinshley

Licensed Embalmer No.

3653

P. O. Address

St. Louis Mo

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.