

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED MAR 3 1942

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7754
Do not use this space

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 1115
 (b) Township Liberty Primary Registration District No. 6021 Registered No. 2
 (c) City Knob Lick (d) Street No. 1 St. 97
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da. 0

2. PRINT FULL NAME

(a) Residence, No. Rouse Murnsb St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Murnsb

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 13/1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>69</u>	<u>0</u>	<u>22</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Home Maker
 10. Date deceased last worked at this occupation (month and year) 2 years 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knob Lick, St. Francois Co., Mo.

FATHER 13. NAME Arnold James Tomlinson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Mattie Eaves

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knob Lick, St. Francois Mo.

17. INFORMANT George Murnsb (ADDRESS) Knob Lick Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Knob Lick Mo. DATE Jan. 13, 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Oprens Funeral Home, Hannington Mo.

20. FILED 1-13-42 1942 H. G. A. Rydeen Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 10, 1942

22. I HEREBY CERTIFY That I attended deceased from By August investigation Jan 11, 1942
 I last saw her alive on Jan 11, 1942 Death is said to have occurred on the date stated above, at 11 m.

The principal cause of death and related causes of importance were as follows:

Acute Myocarditis Date of onset 932
 Other contributory causes of importance: Suffering with stomach troubles for 2 years would not consult physician

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? ✓
 If so, specify _____

(Signed) Clarence C. Laguerre M. D.
 (Address) Carrollton Mo.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

RECEIVED

District Health Officer No. 14
District File Number 242-141
Date Filed 2-6-42

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,

[Signature], or by

Registered Apprentice No., working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 4084
P. O. Address Farmington, Mich.

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

State File No. 7754
Registrar's No.

Registration District No. 1115

Primary Registration District No. 6021

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Knob Lick
(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 years, months or days)

In this community.....

3. (a) PRINT FULL NAME Louisa Wurmbe

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..... years

7. Birth date of deceased dec 15
(Month) (Day) (Year)

8. AGE: Years 69 Months Days 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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 1-14-1942 (b) F. G. A. Rydeen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois

(c) City or town Farmington Rural
(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 Jan Day.....
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I or saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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?
(Specify type of place)

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

23. Signature..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

S-7754