

-39
X29484

FILED APR 10 1942 1037

Registration District No.

Primary Registration District No. **6112**

Registrar's No. **8**

1. PLACE OF DEATH:

(a) County **St. Clair**
 (b) City or town **Scotium, De Kalb Co.**
 (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.....
 In this community.....
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Clarence Allen Suter

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **male** 5. Color or race **w.** 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if

7. Birth date of deceased **Mar 16 1942**
 (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name **Clester W. Suter**

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

14. Maiden name **Pena Catherine Smith**

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

16. (a) Informant **Jewell M. Smith**

(b) Address **Scotium, Mo**

17. (a) (b) Date thereof (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) **Mar 7-42** (b) **D. Georgano**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **17**
 year **1942** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
 19..... to..... 19.....

that I last saw h..... alive on..... 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Born too soon.

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)

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number 4-42-301

Date Filed 4-7-42

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11821

Registration District No. 1037

Primary Registration District No. 6012

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Jeuneville
(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 _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Clarence A. Tuter

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 mch - 16 - 1949
(Month) (Day) (Year)

8. AGE: Years _____ 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) Burial (b) Date thereof 3-17-49
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jeuneville

18. (a) Signature of funeral director did not have one

(b) Address one -

19. (a) 3-17-49 (b) Don't have one
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mch Day 17
Year 1949 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I have seen him/her live on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Born to soon

Due to (Premature)

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?
(Specify type of place) (e) Means of injury _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Did not have one (M. D. or other) _____

Address _____ Date signed _____

Duration

15-9

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

11821