

No. 2  
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11839

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 8

FILED APR 20 1942  
Registration District No. 1

Primary Registration District No. 6020A

74  
2  
1  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

2. USUAL RESIDENCE OF DECEASED: 94  
(a) State \_\_\_\_\_ (b) County 3  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME John Reuben Cash  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. +93-03-9108

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 2  
year 1942 hour 2 minute A.M.  
21. I hereby certify that I attended the deceased from 1941, 19\_\_\_\_, to 2-26-, 1942  
that I last saw him alive on 2-26-, 1942  
and that death occurred on the date and hour stated above.

4. Sex Male race W.  
5. Color or \_\_\_\_\_  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Patti Cash  
6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased Sept. 24 1878  
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis  
Duration years

8. AGE: Years 63 Months 5 Days 8  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 930

9. Birthplace Bonne Terre Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Employee of St. Joe

11. Industry or business Beal Co.

12. Name Albert Cash

13. Birthplace Don't know 9  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Taylor

15. Birthplace Don't know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Patti Cash

(b) Address Bonne Terre, Mo.

17. (a) Burial (b) Date thereof March 4, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Mem. Park

18. (a) Signature of funeral director C. Z. Boyer  
(b) Address Desloge, Mo.

19. (a) 3-4-42 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

Other conditions Asbestos  
(Include pregnancy within 3 months of death) years

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (Country) (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 H. H. Roebber (M. D. or other M.D.)

Address Bonne Terre, Mo. Date signed 3/3/42

RECEIVED

District Health Officer No. 4  
District File Number 442-419  
Date Filed 4-9-42

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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.....

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

working under my personal supervision.

Signed C. Z. Burger

Licensed Embalmer No. 1671

P. O. Address Deerfield Ill

**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. 11829

Registration District No. 715

Primary Registration District No. 6020a

Registrar's No.

1. PLACE OF DEATH: *St Francis*

(a) County.....

(b) City or town.....  
(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)

3. (a) PRINT FULL NAME *John Reuben Pash*

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. *m*

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 *63* Months *5* Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

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..... (Month) (Day) (Year)

(Burial, cremation, or removal)

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

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

(b) Address.....

19. (a) *May 6, 1942* (b) *M. W. Hawkin*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* Day..... Year *1942* hour..... minute..... a.m.

21. I hereby certify that I attended the deceased from..... 19.....; that I am a physician who lives 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)

PHYSICIAN

Major findings:  
Of operations.....

Of autopsy.....

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?.....

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

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

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

SUPPLEMENTARY

11839