

FILED JUN 19 1942

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 773

Primary Registration District No. 4405

Registrar's No. 60

1. PLACE OF DEATH:

(a) County St. Francois
 (b) City or town Farmington
 (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)

3. (a) PRINT FULL NAME OLA MAE WHITE

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

4. Sex Female 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 (Day) (Year)7. Birth date of deceased Aug. 4 1937
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
4 9 10 hr. min.9. Birthplace Farmington Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name James Ray White
 13. Birthplace Madison Ill.
 (City, town, or county) (State or foreign country)
 14. Maiden name Mrs. Day
 15. Birthplace Plattenville Ill.
 (City, town, or county) (State or foreign country)

16. (a) Informant James Ray White(b) Address Farmington, Mo.17. (a) Burial (b) Date thereof May 16, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Parkview Cemetery18. (a) Signature of funeral director Neider Funeral Home(b) Address Farmington, Mo.19. (a) 5-15-42 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
year 1942 hour 11 minute A M.21. I hereby certify that I attended the deceased from Duties 19to May 14 1942

that I last saw him alive on _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death Accidental Drowning Duration _____Just Verdict We the jury feel the deceased came to his death by accidental drowning

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) Accident 094(b) Date of occurrence May 14, 1942(c) Where did injury occur? Farmington St. Francois Mo
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Rack Quarry
While at work? No (Specify type of place) (e) Means of injury Drowning23. Signature James Lane (M.D. or other) _____
Address Farmington Date signed 5/14/42

RECEIVED

District Health Officer No. 4

District File Number 642-714

Date Filed 6-10-42

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

Bert J. Miller

Licensed Embalmer No. 3752

P. O. Address Farmington, 2

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 18904

Registration District No. 973

Primary Registration District No. 4464

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Farmington
(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 _____ years, months or days

3. (a) PRINT FULL NAME Ola May White

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 S

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

7. Birth date of deceased Aug - 4 - 1942
(Month) (Day) (Year)

8. AGE: Years 4 Months 9 Days 11 (If less than one day min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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) May 11, 1942 (b) Byrdie Bukhmetz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Francois

(c) City or town Farmington
(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 May Day 14 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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? _____

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

