

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED AUG 21 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

26831

State File No. _____

Registration District No. 104

Primary Registration District No. 3608

Registrar's No. 236

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton City

(c) Name of hospital or institution: State Hospital No 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 44-5-29d
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(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 James Styles

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 25
year 1942 hour 6 minute 15 P. M.

4. Sex M. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased DK
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-1-1941, to 7/25/42, 1942
that I last saw him alive on 7/7/42, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lower lip

8. AGE: Years 58 Months _____ Days _____
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation None

Major findings: 450
Of operations _____

Of autopsy _____

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

MOTHER FATHER { 11. Industry or business _____

12. Name DK

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

14. Maiden name DK

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

16. (a) Informant Record

(b) Address _____

17. (a) Removal (b) Date thereof 9 28 42
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Columbia MD

18. (a) Signature of funeral director G. O. Roberts

(b) Address Columbia MD

19. (a) 7-28-42 (b) Josie Morawhoff
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(a) Means of injury 0

23. Signature George J. Reins (M. D. or other) MD

Address Fulton Mo Date signed 7/27/42

1147 (Licensed Embalmer's Statement on Reverse Side)

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

4
1
2

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.

STANDARD CERTIFICATE OF DEATH

State File No. 26831

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Callaway
- (b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: State Hosp. #1
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Jamer Styles

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

5. Color or race W

6. (a) Single, widowed, married, divorced _____

4. Sex _____

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 88

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 _____

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, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-28-42

(Date received local registrar)

(b) Josie Morinichoff

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____

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 _____

Duration _____

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

MOTHER FATHER

SUPPLEMENTARY

