S. No. 2
—1-4-41
5-17-39
PI X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

27495

State File No.

FILED AUG 21 1942

Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 62

50
1
1

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Crystal City
(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 Missouri (b) County 50

(c) City or town 1
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME UNIDENTIFIED FLOATER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race 0

6. (a) Single, widowed, married, divorced 9

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 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Mo

18. (a) Signature of funeral director Gentry R. Pollitt

(b) Address Crystal City, Mo

19. (a) July 29, 1942 (Date received local registrar) (b) H. S. Gibson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 28TH year 1942 hour 10 AM 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.

	Duration
Immediate cause of death DROWNDING IN MISSISSIPPI RIVER.	
Due to	
Due to	
Other conditions (Include pregnancy within 5 months of death)	
Major findings: Of operations	
Of autopsy	

183
99

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

(b) Date of occurrence ? 0.50

(c) Where did injury occur? RIVERSIDE (City or town) (County) MO (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 F.P. JOHNSTON (M.D. or other) CORONER

Address FESTUS, MO Date signed

0 1265 (Licensed Embalmer's Statement on Reverse Side)

AUG 2 1954

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.

No. 2B
-8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27495

Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 62

1. PLACE OF DEATH:

(a) County: Jefferson

(b) City or town: Crystal City
(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 .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Unknown (b) County: Unknown

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? Unknown (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Unidentified Floater

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

3. (c) Social Security No. .....

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Unknown

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

8. AGE: Years ~~50 (?)~~ Months ..... Days ..... If less than one day: hr. ..... min.
Unknown

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

10. Usual occupation: Unknown

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: None

(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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him 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: Unknown

(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 .....

SUPPLEMENTARY