

FILED NOV 13 1947
Registration District No. 297

Primary Registration District No. 6022

Registrar's No.

1. PLACE OF DEATH:

(a) County Ray Rayville Rural

(b) City or town Rayville Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Richmond Trust
(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 Missouri (b) County Ray

(c) City or town Rayville Rural
(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 Pauline Beock

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25 year 1942 hour 8 minute P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Samuel Brock

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Dec. 14 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 25 1942 and that death occurred on the date and hour stated above.

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

73 10 11 hr. min.

Immediate cause of death Cerebral Hemorrhage

9. Birthplace Unknown Poland 4
(City, town, or county) (State or foreign country)

Due to arterio-sclerosis

10. Usual occupation House Wife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

MOTHER FATHER { 12. Name Frank Keehn

{ 13. Birthplace Poland 4
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Poland 4
(City, town, or county) (State or foreign country)

PHYSICIAN Jza

Underline the cause to which death should be charged statistically.

16. (a) Informant Josephine Fortik

(b) Address Chicago Ill.

17. (a) Burial (b) Date thereof Oct. 28, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond Mo.

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?.....

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

(b) Address Richmond MO.

19. (a) October 27-42 (b) Mrs. Ches W. Haggard
(Date received local registrar) (Registrar's signature)

While at work (Specify type of place) (c) Means of injury

23. Signature [Signature] (M. D. or other)

Address [Signature] Date signed 10-28-42

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

89
0
0

89
0
0

RECEIVED

District Health Officer No. 8,

File Number

11-12-42

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, W. H. H.
....., Registered Apprentice No.
working under my personal supervision.

Signed

W. H. H.

Licensed Embalmer No. 2073

P. O. Address Richmond Mo.

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.