

No. 2
 5-17-39
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FILED NOV 9 1942
 Registration District No. 1379

Primary Registration District No. 6078

State File No. _____

Registrar's No. 63

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

1. PLACE OF DEATH:
 (a) County STE. GENEVIEVE
 (b) City or town RURAL JACKSON TOWNSHIP
(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 _____
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Genevieve
 (c) City or town Rural Jackson Twp.
(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 DOLOR BILLY
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct. day 11th
 year 1942 hour 2 minute 45 P. M.
 21. I hereby certify that I attended the deceased from Feb 11
 1942 to Oct. 11th 1942
 that I last saw him alive on Oct. 11 1942
 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife HELOENA CARRON 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased MARCH 18 1872
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Stomach. Duration 17 years

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>6</u>	<u>23</u>	_____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions Hb
(Include pregnancy within 5 months of death)

9. Birthplace KINSEY MISSOURI
(City, town, or county) (State or foreign country)
 10. Usual occupation FARMER

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Major findings: Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name JOSHUA BILLY
 13. Birthplace MONTERAL CANADA
(City, town, or county) (State or foreign country)
 14. Maiden name MARSHINE PRIMO
 15. Birthplace KINSEY MISSOURI
(City, town, or county) (State or foreign country)
 16. (a) Informant Robert Billy
 (b) Address Bribery, Mo
 17. (a) BURIAL (b) Date thereof 10-13-42
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation BLOOMSBDALE MO
 18. (a) Signature of funeral director Les C. Basky
 (b) Address St. Genevieve Mo
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Arthur E. Geyman (M. D. or other) M.D.
 Address 216 Grandview Mo Date signed Oct 12/42

RECEIVED

District Health Officer No. 3

District File Number 142-114

Date Filed 11-7-42

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 *Loe C. Basler*

Licensed Embalmer No. 1985

P. O. Address *St. Genevieve 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34944
Registrar's No. 63

Registration District No. 349 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St Genevieve
(b) City or town Paul
(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 Dolor Billy
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 Mar 18
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 13 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (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) Dec 3/42 (b) T. W. Douglas
(Date received by 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 Dec year 1942 hour _____ minute _____ M.

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

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1942

S-34944