

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36517

FILED DEC 11 1942

State File No. _____

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 318

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Green-Smith Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuyler

(c) City or town Coatsville Rural
(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.? _____ years.

3. (a) PRINT FULL NAME Benjamin Robert Squires

3. (b) If veteran, name war

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25
year 1942 hour 1 minute 25 P.M.

21. I hereby certify that I attended the deceased from November 15, 1942 to Nov. 25, 1942
that I last saw him alive on November 25, 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 widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July 28 1863
(Month) (Day) (Year)

Immediate cause of death: Pneumonia due to prostate hypertrophy probably malignant causing bladder obstruction & kidney damage

Due to _____

Due to Developing gradually

Other conditions None
(Include pregnancy within 3 months of death)

8. AGE: Years 79 Months 3 Days 27
If less than one day hr. _____ min. _____

9. Birthplace Pinville La. (City, town, or county) (State or foreign country) 1

10. Usual occupation Farmer

11. Industry or business _____

Major findings: Complete obstruction of urethra, unable to do operation

Of operations _____

Of autopsy _____

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

MOTHER FATHER

12. Name Nemise Squires

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

14. Maiden name Nancy Evans

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

16. (a) Informant Mrs. Faye Neatch

(b) Address Lincolnton Mo.

17. (a) Burial (b) Date thereof Nov-27-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Coatsville

18. (a) Signature of funeral director Morehead

(b) Address Lincolnton

19. (a) 12/4/42 (b) Mrs. J. W. Wagon
(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature George E. Green (M. D. or other) MD

Address Kirksville, Missouri Date signed 12-3-42

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

33

DEC 30 1942

Handwritten notes, possibly "C. H. ..."

Handwritten notes, possibly "A. ..."

Handwritten notes, possibly "C. ..."

RECEIVED

District Health Officer No. 10

Case No. 12-42-4046

Date Dec. 10-1942

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.....

True Minnie Morehead Registered Apprentice No.....

working under my personal supervision.

Signed *True Minnie Morehead*.....

Licensed Embalmer No. 3731-3680

P. O. Address Lancaster, Ma.

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.