

FILED DEC 10 1942
Registration District No. **316**

Primary Registration District No. **3061**

Registrar's No. **45**

94
25
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County St. Francois
 (b) City or town Flat River
(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

3. (a) PRINT FULL NAME Charles Walter Degonia
 (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex M **5. Color or race** W
6. (a) Single, widowed, married, divorced, or separated Married
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 1 - 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 6
If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____
MOTHER FATHER
12. Name Frank Degonia
13. Birthplace St. Francois Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Matthe Banks
15. Birthplace Elvins Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Degonia
(b) Address Flat River Mo

17. (a) Burial St. Mary's **(b) Date there** 11-9-1942
(Burial, cremation, or removal) (City or town) (County) (State) (Month) (Day) (Year)

(c) Place: burial or cremation Layne Cemetery EVNS

18. (a) Signature of funeral director Baldwell But
(b) Address Flat River Mo

19. (a) 11-16-1942 **(b) Byrdie Bukhmaster**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Francois
 (c) City or town Flat River
(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.? No years 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8th
 year 1942 hour 9 minute P M.

21. I hereby certify that I attended the deceased from Nov 8th
1942, to Nov 8th, 1942
 that I last saw alive on Nov 8th, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death malnutrition
 Due to _____
 Due to _____
 Other conditions 150
(Include pregnancy within 3 months of death)

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

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 [Signature] (M. D. or other) _____
 Address Flat River Mo Date signed 11/9/42

RECEIVED

District Health Officer No. 3

District File Number 1242-1458

Date Filed 12-8-42

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.....

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, above space should be left blank.