DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN -7 1943

Registration District No. 3:16

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41789

Primary Registration District No. 6075

Registrar's No. 170

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

1. PLACE OF DEATH:
(a) County: St. Francois
(b) City or town: Farmington, RURAL, St. Francois Co.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 11 Months - 12 Days
(Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Franklin Co.
(c) City or town: St. Clair
(If outside city or town limits, write "RURAL")
(d) Street No.:
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: HOMER JEFFRIES
3. (b) If veteran, name war: Unknown
3. (c) Social Security No.: Unknown
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Dead Unknown
6. (c) Age of husband or wife if alive: Dead years
7. Birth date of deceased: Sept (Month) 12 (Day) 1871 (Year)

8. AGE: Years	Months	Days	If less than one day
70	3		hr. min.

9. Birthplace: Franklin Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Merchant
11. Industry or business: Poultry Business
12. Name (Father): James Jeffries
13. Birthplace (Father): Missouri (City, town, or county) (State or foreign country)
14. Maiden name (Mother): Sarah Lakin
15. Birthplace (Mother): Missouri (City, town, or county) (State or foreign country)
16. (a) Informant: Records State Hospital No. 4
(b) Address: Farmington, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 15, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Odd Fellows - St. Clair, Mo
18. (a) Signature of funeral director: Sherwood Ketchell
(b) Address: St. Clair, Mo
19. (a) Dec. 22, 1942 (Date received local registrar) (b) Byrdie Buhrmester (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12 — year 1942 hour 3 minute 45 A.M.
21. I hereby certify that I attended the deceased from Sept. 11 — 1942, to Dec. 12 1942, that I last saw him alive on Dec. 11 — 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	3 days.
Due to Psychosis, Arteriosclerosis Cerebral	2 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: No 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:
(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: Otto H. Schwedde, M.D. (M. D. or other)
Address: Farmington State Hosp. Mo. Date signed 12-12-42

1196

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 143-15-5

Date Filed 1-6-43

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 Sherwood Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair 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.

7. S. No. 2B
0M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41789

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 170

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

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

3. (a) PRINT FULL NAME: Homer Jeffries
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: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Sept (Month) 12 (Day) 87 (Year)
8. AGE: Years 70 Months 3 Days If less than one day hr. min.
9. Birthplace: Mo. (City, town, or county) (State or foreign country)
10. Usual occupation
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
(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 Feb Day 12 year 1942 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: Pneumonia / Bronchial — Duration 8 days
Due to: Psychosis arteriosclerosis cerebral — 2 yrs
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 101
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
(c) Where did injury occur? (City or town) (County) (State)
(b) 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. Signed Otto A Schulde M.D. (M. D. or other)
Address State Hosp. Farmington Mo. Date signed 2-2-43

SUPPLEMENTARY