No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 18 1943

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6086

Registration District No. 10 | Primary Registration District No. 4123 | Registrar's No. 7

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

**1. PLACE OF DEATH:**
(a) County Clark
(b) City or town Wayland
(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)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Clark
(c) City or town Wayland
(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.? 0 years.

3. (a) PRINT FULL NAME Robert Hand
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 2 Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sep 3 (Month) - 1861 (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 3 | 17 | hr. min. |

9. Birthplace Alexandria (City, town, or county) Mo (State or foreign country)
10. Usual occupation Retired merchant
11. Industry or business General Store
FATHER
12. Name David Hand
13. Birthplace (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Hannah Lemaster
15. Birthplace (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Mrs F Hawkins
(b) Address Hannibal Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Oakland Cemetery
18. (a) Signature of funeral director H F Kircher
(b) Address Wayland
19. (a) 1-19-43 (Date received local registrar) (b) Perry S Boston (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 15 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Found Dead | |
| Nature Cause Probably Heart Attack | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| 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)
(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 J L McConnell Conner Clerk Co (M. D. or other)
Address Revere Mo Date signed 1-15-43

1073

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-43-312
Date Filed FEB 16 1943

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 H. F. Kircher

Licensed Embalmer No. 2611

P. O. Address Wayland

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

. S. No. 2B
OM—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6086

Registration District No. ..... Primary Registration District No. 4123 Registrar's No. .....

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Clark

(b) City or town Wayland
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Clark

(c) City or town Wayland
(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 Robert Hand

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 Mid

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

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

7. Birth date of deceased Sept 3 - 1861
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 17 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)

MOTHER FATHER
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 June day 15
year 1942 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Found dead - natural cause | |
| Due to probably heart attack | |
| Due to Myocarditis | |
| Other conditions (Include pregnancy within 3 months of death) | |

93 ✓

Major findings:
Of operations .....
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. Signature J. L. McConnell Coroner Clark Co (M. D. or other)
Address Revere - Mo Date signed 3-25-43