No. 2
-5-42
-17-39
X32873

7812

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 16 1943

Registration District No. 329

Primary Registration District No. 1148

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Scott County
(b) City or town Fornfelt, Mo
(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 49 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott.
(c) City or town Fornfelt, Mo.
(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 0

3. (a) PRINT FULL NAME Jesse Cleveland Bain
3. (b) If veteran, name war
3. (c) Social Security No. 702-09-5268

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Fannie
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Feb. (Month) 10 (Day) 1888 (Year)

8. AGE: Years 54 Months 10 Days 24 If less than one day hr. min.

9. Birthplace Fairfield (City, town, or county) Ill. (State or foreign country)
10. Usual occupation Fireman
11. Industry or business Industry
FATHER
12. Name Thomas Bain
13. Birthplace Fairfield (City, town, or county) Ill. (State or foreign country)
MOTHER
14. Maiden name Rose Loyd
15. Birthplace Fairfield, (City, town, or county) Ill. (State or foreign country)
16. (a) Informant Family
(b) Address Fornfelt, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park.
18. (a) Signature of funeral director Seabaugh Funeral Home
(b) Address Cape Girardeau, Mo.
19. (a) Jan 6, 1942 (Date received local registrar) (b) Mrs W. L. Tomlinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4
year 1943 hour 7:10 minute M.
21. I hereby certify that I attended the deceased from 12/26/42, 19, to 1/3/43, 19;
that I last saw him alive on 1/3/42, 19;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Myocarditis Tuberculosis ✓ | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations none | |
| Of autopsy none | |

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 A. E. Lee M.D. (M. D. or other)
Address Illmo Mo. Date signed 1/5/43

1124

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 243-23
Date Filed 2-8-43

FEB 26 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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.**

S. No. 2B
M—8-21-41
P 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. 7812

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

**1. PLACE OF DEATH:**

(a) County Scott

(b) City or town Fornfelt (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 49 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Scott

(c) City or town Fornfelt (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 Jesse C. Bain

3. (b) If veteran, name war .....

3. (c) Social Security No. 702-09-5268

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 Feb 10 (Month) 1888 (Day) (Year)

8. AGE: Years 54 Months 10 Days 24 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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 Jan day 4 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.

Immediate cause of death Myocarditis tuberculosis pulmonary

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations .....

Of autopsy .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

13 pl

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 A. E. Lee M.D. (M. D. or other)

Address Oelmomo Date signed 3/30/43

SUPPLEMENTARY