

No. 2  
-5-42  
17-39  
X3287

State File No. ....

FILED MAR 31 1943

Registration District No. ....

Primary Registration District No. 3007

Registrar's No. 71

1. PLACE OF DEATH:

(a) County BUTLER  
(b) City or town Poplar Bluff  
(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  
In this community 25 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BUTLER  
(c) City or town Poplar Bluff MO  
(d) Street No.  
(e) Citizen of foreign country?  
If yes, name country.

3. (a) PRINT FULL NAME FRANK LOGE

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced

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

7. Birth date of deceased JUNE 4 1869

8. AGE: Years 69 Months 9 Days 29

9. Birthplace EVANSVILLE IND

10. Usual occupation FARMER

11. Industry or business

12. Name HENRY LOGE

13. Birthplace EVANSVILLE IND

14. Maiden name SARAH ELIZABETH YOUNG BLOOD

15. Birthplace IND

16. (a) Informant Lester Loge

(b) Address 811 Chambers St St Louis MO

17. (a) BURIAL (b) Date thereof MAR 5 1943

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. J. Phelps

(b) Address Poplar Bluff MO

19. (a) 3-28-43 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 3 year 1943 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Mar. 2, 1943 to Mar 2, 1943 that I last saw him alive on Mar 2, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death carcinoma left mandible + adjacent tissues

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 45d 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?

(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 J. W. Gronda M. D. or other Address Poplar Bluff MO Date signed 3-28-43

Duration

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

9.2

RECEIVED

District Health Office No. 2,

District File Number 343-410

Date Filed 3-30-43

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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 W. J. Phelps

Licensed Embalmer No. 3231

P. O. Address Papayan Bleuff me

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9749  
Registrar's No. 71

Registration District No. 43

Primary Registration District No. 2007

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Paplar Bluff  
(If outside city or town limits, write "RURAL" and name of town) (p)  
(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 \_\_\_\_\_  
In this community 25 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank Loge

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 June 4  
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 20 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day \_\_\_\_\_  
Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

