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M-9-4-41  
5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11311

State File No.

Registrar's No. 78

FILED APR 20 1943

Registration District No. 316

Primary Registration District No. 3059

94  
2  
1

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

1. PLACE OF DEATH:

(a) County: St Francois

(b) City or town: Bonnetere Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home 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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: St Francois

(c) City or town: Bonnetere  
(If outside city or town limits, write "RURAL")

(d) Street No. 203 W. School St  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: Mary Ann Whelen

3. (b) If veteran, name war: ✓

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13 year 43 hour 2-15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Feb 16th 1943 to Mar 13 1943 that I last saw him alive on Mar 11th 1943 and that death occurred on the date and hour stated above.

5. Color or race: white

6. (a) Single, widowed, divorced, ~~married~~ widowed

6. (b) Name of husband or wife: Mary Ann (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Feb 17th 1867  
(Month) (Day) (Year)

Immediate cause of death: cerebral hemorrhage

Due to: unknown

Due to: \_\_\_\_\_

8. AGE: 76 Years Months \_\_\_\_\_ Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Iron Mountain Mo  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death): 830

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation: House wife

11. Industry or business: \_\_\_\_\_

12. Name: Mitchell Laughlin

13. Birthplace: Ireland (City, town, or county) (State or foreign country)

14. Maiden name: Mary Conning

15. Birthplace: Virginia (City, town, or county) (State or foreign country)

16. (a) Informant: Wm L Laughlin

(b) Address: Farmington Mo.

17. (a) Calvary (b) Date thereof: Mar 16-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Farmington Mo.

18. (a) Signature of funeral director: Queret Sparks

(b) Address: 741st River Mo.

19. (a) 3-16-43 (b) Bondie Buhmester  
(Date received local registrar) (Registrar's signature)

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: P. L. Lyons (M. D. or other) \_\_\_\_\_

Address: Bonnetere Mo Date signed: 3-15-43

RECEIVED

District Health Officer No. 4  
District File Number 443-1988  
Date Filed 4-5-43

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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 Bleett Sparks  
Licensed Embalmer No. 4287  
P. O. Address Flat River

**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.