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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 15 1943

Registration District No. 314

Primary Registration District No. 4459

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County St. Clair

(b) City or town Osceola

(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 all of life (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Osceola
(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 Lindsey Shobber

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1943 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from Jan 4-43
to Mar 31 1943
that I last saw him alive on Feb - 1943
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased 9 15 1861
(Month) (Day) (Year)

Immediate cause of death malignancy of stomach

Due to _____

Due to _____

Other conditions mitral insufficiency
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

81 6 16 hr. min.

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

10. Usual occupation Tax Collector

11. Industry or business _____

12. Name W. K. Kucser

13. Birthplace not known (City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace not known (City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant James Bennett

(b) Address Osceola Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-43
(Month) (Day) (Year)

(c) Place: burial or cremation Osceola

18. (a) Signature of funeral director Oscar [unclear]

(b) Address Osceola Mo

19. (a) 4-4-43 (Date received local registrar) (b) [Signature] (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? _____

(Specify type of place) (c) Means of injury _____

23. Signature Ruth Seecers (M. D. or other) _____

Address Osceola Mo Date signed 4-4-43

RECEIVED
District Health Officer No. 7,
District File Number 4-43-237
Date Filed 5-11-42

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 Paul F. Stone
Licensed Embalmer No. 3990
P. O. Address Ossola 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.