

St. No. 2
-11-10-39
5-17-39
PI X2149

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19305

FILED JUN 11 1943

Registration District No. 256

Primary Registration District No. 6209

Registrar's No. 21

1. PLACE OF DEATH:

(a) County TEXAS
(b) City or town RURAL PINEY J
(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 3 YRS (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County TEXAS
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. 2MI N. HOUSTON
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME FRANK LEE JUSTICE

3. (b) If veteran, name war _____ 3. (c) Social Security No. 545-01-7444

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

6. (b) Name of husband or wife ESTER JUSTICE 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased JAN 20 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days 22 If less than one day
hr. min.

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

10. Usual occupation MACHANIC

11. Industry or business _____

MOTHER FATHER
12. Name MOSES JUSTICE
13. Birthplace GEORGIA
(City, town, or county) (State or foreign country)
14. Maiden name LUCENIA RUSTIN
15. Birthplace MO.
(City, town, or county) (State or foreign country)

16. (a) Informant MARY JANE HINKLE

(b) Address HOUSTON, MO

17. (a) BURIAL (b) Date thereof 5/24/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOUSTON

18. (a) Signature of funeral director Raymond V. Elliot

(b) Address HOUSTON, MO

19. (a) 5/24/43 (b) Mrs. Ella Duff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 22
year 1943 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dead
When found, 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 Surmised to be Heart failure
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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? (a) Means of injury _____

28. Signature J. W. ... (M. D. or other) _____
Address ... Date signed 5-24-43

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

07
00
00

RECEIVED

District Health Officer No. 5,

District File Number 543360

Date Filed 6-8-43

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 Frank E. Wood

Licensed Embalmer No. 4074

P. O. Address Houston, 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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 356

Primary Registration District No. 6204

Registrar's No. 21

1. PLACE OF DEATH:

- (a) County Jackson
- (b) City or town Rural
(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)

3. (a) PRINT FULL NAME Frank Lee Justice

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 M

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

7. Birth date of deceased Jan 20 1900
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days _____ If less than one day _____ min.

9. Birthplace _____
(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)
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 Mar Day 22
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 _____

Old pulmonary
Due to _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

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? _____
(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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-19305