

D. Chapman

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22112

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

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41
X-116

FILED JUL 14 1943 270

Registration District No. 270 Primary Registration District No. 5910 Registrar's No. 46

1. PLACE OF DEATH

(a) County St. Louis

(b) City or town St. Louis Rural

(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 yrs (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis Rural

(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 Leah Zachery

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex Female 5. Color or race Colored

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 January 8 1903

(Month) (Day) (Year)

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

40 | 5 | 27 | _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business NONE

MOTHER FATHER

12. Name Sam Carrington

13. Birthplace Don't Know

14. Maiden name Fannie Blackston

15. Birthplace Don't Know

16. (a) Informant Daisy Guy Thomas

(b) Address 518 Dwyer St. Union Spas

17. (a) Removal (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Monroe Louisiana

18. (a) Signature of funeral director German Undert Co

(b) Address Steele, Missouri Box 121

19. (a) 7-12-43 (b) Jessie H. Marker

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 year 1943 hour 18:05 minute 9 M.

21. I hereby certify that I attended the deceased from March 5 1943 to July 5 1943 that I last saw her alive on June 15 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Bright's Disease ✓

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 J. R. Chapman (M. D. or other) _____

Address Steele Mo. Date signed 7-7-43

(Licensed Embalmer's Statement on Reverse Side)

APR 16 1962

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.....

John H. German

Registered Apprentice No. *344*

working under my personal supervision.

Signed: *Joe R. Stovall*

Licensed Embalmer No. *3100*

P. O. Address. *Blytheville*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 46

Registration District No. 270

Primary Registration District No. 5910

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

1. PLACE OF DEATH:

(a) County Pemiscot
(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

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased: Jan 8 (Month) (Day) (Year)

8. AGE: Years 40 Months 5 Days 2 (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) (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)

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 July year 1943 hour 1 minute 15 M.

21. I hereby certify that I attended the deceased from 1 1943; that I saw him/her die on July 8 1943; and that death occurred on the date and hour stated above. Immediate cause of death Bright's Disease (acute) Duration

Due to n.m.o.

Due to

Other conditions (Include pregnancy within 3 months of death) 130

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) (c) Means of injury

23. Signature W. Chapman (M. D. or other)

Address State, Mo Date signed

Registration District No. 270 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Deming
(b) City or town _____
(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

Leah Zachery

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

4. Sex Female 5. Color or race C 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 _____ (Month) (Day) (Year)

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

9. Birthplace Wesport, Mo. (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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 July year 1943 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 _____

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 _____

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

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.