S. No. 1
M. 1-12
17-39

AUG 1 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26283

Registration District No. 335 Primary Registration District No. 4492 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Scott Co
(b) City or town: Oran Mo
(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 years, months or days) In this community 76 years

2. USUAL RESIDENCE OF DECEASED:
(a) State 100 (b) County 4
(c) City or town 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME John B. Le Grand
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 Married
6. (b) Name of husband or wife Mageline
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 12 (Day) 1867 (Year)

8. AGE: Years 76 Months 6 Days 12 If less than one day hr. — min.

9. Birthplace Scott Co, Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business —

FATHER
12. Name Michel Le Grand
13. Birthplace France 5 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Angeline Dumey
15. Birthplace Franel 5 (City, town, or county) (State or foreign country)

16. (a) Informant Mike Dunsburger
(b) Address Oran Mo - R.F.D.
17. (a) Burial, cremation, or removal Guardian Angel Cem Date thereof Aug - 6 - 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Oran Mo
18. (a) Signature of funeral director Bigslinghoff & Hubbard
(b) Address Chaffee Mo
19. (a) 8/12/43 (Date received by local registrar) (b) W. C. Eckman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 4 year 1943 hour 5 minute a.m.
21. I hereby certify that I attended the deceased from April 10, 1943 to 8-4 ~~June 10~~, 1943; that I last saw him alive on 2 June 20, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Decompensated myocarditis with atrial sclerosis — Duration 6 mo
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. A. Ritter, M.D. (M. D. or other)
Address Cape Girardeau, Mo Date signed 8-5-43

792

(Licensed Embalmer's Statement on Reverse Side)

AUG 24 1943

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: Mamie Brigling Huff

Licensed Embalmer No. 3242

P. O. Address: Choffee 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Aug.

State File No.

Registration District No. 335 Primary Registration District No. Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Oran, Mo
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Oran
(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 John B Le Grand

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race W

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

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 76 Months 6 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 8 day 5 year 1943 hour 3 minute 9 M.

21. I hereby certify that I attended the deceased from , 19 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

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-26283