

32424

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 8 1943
Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 328

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month 15 das.
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. Unknown
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARTHA E. COZEAN

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race W.

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

6. (b) Name of husband or wife Elias M. Cozean

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased June 22, 1854
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>2</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Zenith Stephens

13. Birthplace Madison County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Bollinger County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Burial Farmington, Missouri

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 9-23-43
(Month) (Day) (Year)

(c) Place: burial or cremation Snowdenville Cem., Cornwal

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Missouri

19. (a) Sept 25-1943 (b) Bondie Bukhmaster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21,
year 1943 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from August 6, 1943 19____ to September 21, 1943 19____
that I last saw her alive on September 21, 1943 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis & senile infarction

Due to _____

Due to _____

Other conditions Fracture of osseous pelvis
(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) 094 ✓

(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? l, Mo.

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. Stephens (M. D. or other) md

Address 408 N. First St. Farmington, Mo. Date signed 9-22-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

1190

RECEIVED

District Health Officer No. 4
District File Number 1043-2765
Date Filed 10-5-43

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.....
Licensed Embalmer No. 4084
P. O. Address Birmingham

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. Oct.

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hosp. no. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 15 da.
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Martha E. Cozear

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

4. Sex F 5. Color or race W

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

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

7. Birth date of deceased June 22
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 Mo. (b) County St. Francois

(c) City or town Farmington
(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 Sept. year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis
senile infirmities

Due to _____

Due to _____

Other conditions Fracture of wrist
(Include pregnancy within 3 months of death) of Pelvis.

Major findings:
Of operations _____

Of autopsy 1869

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) Accident

(b) Date of occurrence Aug. 26 1943

(c) Where did injury occur? Farm of Mr. State Hosp.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Hosp No 4

While at work? No (Specify type of place) (e). Means of injury fall out of bed

23. Signature M. J. Ferguson (M. D. or other) MD

Address 408 N. Euclid Date signed 10/15/43
Farmington Mo

SUPPLEMENTARY

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

32424