

No. 5-17-39 I X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32703

State File No.

OCT 13 1943

Registration District No. 325

Primary Registration District No. 6098

Registrar's No. 81

1. PLACE OF DEATH:

(a) County Schuyler

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

(c) Name of hospital or institution: City  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Miss (b) County 069

(c) City or town Madison  
(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 Irving Campbell Rector

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him live on 11/10/10 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 0

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

7. Birth date of deceased Nov 2 1904  
(Month) (Day) (Year)

Immediate cause of death Wilhelm's auto accident

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1700-8

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

37 10 10 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Special Investigator

11. Industry or business \_\_\_\_\_

12. Name Schuyler Rector

13. Birthplace Schuyler mo  
(City, town, or county) (State or foreign country)

14. Maiden name Jessie Stanley

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

16. (a) Informant ward Rector

(b) Address Madison Miss

17. (a) Burial (b) Date thereof Sept 14 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blomond cemetery

18. (a) Signature of funeral director Lloyd Moore

(b) Address 1901 ...

19. (a) Sept 14 1943 (b) City Justice  
(Date received local registrar) (Registrar's signature)

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 JH Keller (M.D. or other) \_\_\_\_\_

Address Lancaster, Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

1278

(Licensed Embalmer's Statement on Reverse Side)

60 barnar

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 16-43-1697

Date Filed OCT 11 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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Lloyd Moore

Licensed Embalmer No. 3137

P. O. Address Douglas 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.

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 Schuyler

(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 3 da.  
years, months or days

3. (a) PRINT FULL NAME Irving C. Rector

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 s

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

7. Birth date of deceased Nov. 2 - 1914  
(Month) (Day) (Year)

8. AGE: Years 31 Months 10 Days no. 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisc (b) County \_\_\_\_\_

(c) City or town Madison  
(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 Day 12 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 Killed in car automobile wreck.

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) accident

(b) Date of occurrence Sept. 12 - 1943

(c) Where did injury occur? Schuyler Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Car

Car trunk on bus with Brakes  
(Specify type of place) (a) Means of injury

23. Signature J. H. Keller (M. D. or other) Physician

Address Saint Charles Mo Date signed Oct 16

SUPPLEMENTARY

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

32703

MAR 1 31944