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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43599

FILED JAN 6 1944

State File No. _____

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 369

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

(d) Length of stay: In hospital or institution 2 mos. 21 das.
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage County

(c) City or town Belle
(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 ETHEL J. LEASE

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race W.

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

6. (b) Name of husband or wife Albert H. Lease

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

7. Birth date of deceased April 9, 1880
(Month) (Day) (Year)

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

63	8	1	hr. min.
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9. Birthplace Waverly Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name William Hursh

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

14. Maiden name Cathrine Myers

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

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

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 12-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belle Cem., Belle, Mo.

18. (a) Signature of funeral director Morton Funeral Home

(b) Address Lynn, Missouri

19. (a) Dec 16 1943 (b) Byadie Buhrmester
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10,
year 1943 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from
Sept. 19, 1943 19 to December 10, 1943
that I last saw h. ET. alive on December 10, 1943 19
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis
Duration _____

Due to _____

Due to _____

Other conditions 97
(Includes 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 M. J. Langdon (M. D. or other) Phys.

Address 408 W. 1st St. Date signed 12-14-43

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

94
0
0

94

0

0

1196

(Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

RECEIVED

District Health Officer No. 4
District File Number 144-3129
Date Filed 1-5-44

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 Burl J. Miller
Licensed Embalmer No. 3752
P. O. Address Farmington, 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.