DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3702

State File No.

Registration District No. 237 Primary Registration District No. 5820 Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town 5 mi. N.W. of Gideon, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Anderson Twp Station Hospital (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 Michigan (b) County Unknown

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

(d) Street No. 1115 Albany Ave. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Donald J. Paulick

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 Single

6. (b) Name of husband or wife ---

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

7. Birth date of deceased December (Month) 24 (Day) 1923 (Year)

8. AGE: Years 20 Months 0 Days 16 If less than one day hr. min.

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

10. Usual occupation Millhand.

11. Industry or business Industry

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

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Cadet Headquarters.

(b) Address BAAF, Blytheville, Ark.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 12, 44 (Month) (Day) (Year)

(c) Place: burial or cremation Ferndale, Michigan

18. (a) Signature of funeral director J. Schouman

(b) Address Malden Mo

19. (a) Feb-1-44 (Date received local registrar) (b) Bendes Macom (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10 year 1944 hour 4:00 PM minute -- 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 Destruction of vital Centers.

Due to Aeroplane Accident

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 10 January 1944

(c) Where did injury occur 5 mi. N.W. Gideon, Mo. N. Mad. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Country (Specify type of place)

While at work? Yes (e) Means of injury ---

23. Signature C. Mallory Haswell Jr. (M. D. or other) MD

Address MAAF, Malden, Mo. Date signed 1/11/44

538

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 244-304
Date Filed 2-7-44

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 J. S. Scherman

Licensed Embalmer No. 4086

P. O. Address Malden

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.