U. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4549

FILED FEB 9 1944

Registration District No. 379 Primary Registration District No. 6079 Registrar's No. 4

1. PLACE OF DEATH:
(a) County Ste. Genevieve
(b) City or town Rural Ste Genevieve T.S.
(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 1 (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME HARRY O MADISON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE
5. Color or race COLORED
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 Jan (Month) 27 (Day) 44 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 0 hr. 10 min.

9. Birthplace Ste. Genevieve Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name JAMES MADISON
13. Birthplace Ste Genevieve Co (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name ORALIA WHITE
15. Birthplace Ste Genevieve Mo (City, town, or county) Mo (State or foreign country)
16. (a) Informant James Madison
(b) Address Ste. Genevieve Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-44 (Month) (Day) (Year)
(c) Place: burial or cremation Ste. Genevieve Mo
18. (a) Signature of funeral director Leo C. Bagley
(b) Address Ste. Genevieve Mo
19. (a) Jan 27/44 (Date received local registrar) (b) T.W. Douglas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1944 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from Jan 27, 1944, to Jan 27, 1944 that I last saw him alive on Jan 27, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis Neonatorum — Duration
Due to Strangulation by Umbilical cord
Due to
Other conditions (Include pregnancy within 3 months of death) 160C
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. L. Lemming (M. D. ~~or other~~)
Address Ste. Genevieve Mo Date signed 1/27/44

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

500

106

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 244-3364

Date Filed 2-8-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Leo C. Barber

Licensed Embalmer No. 1985

P. O. Address St. Genevieve 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.