

S. No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5141

State File No. _____

FILED MAR 6 1944 318

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 1971

1. PLACE OF DEATH:

(a) County... St. Louis, Mo.

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

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

(d) Length of stay: In hospital or institution... 11 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Jack Getson

3. (b) If veteran, name war... None

3. (c) Social Security No... None

4. Sex... Male

5. Color or race... White

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

6. (b) Name of husband or wife... Rachel Getson

6. (c) Age of husband or wife if alive... 70 years

7. Birth date of deceased... March 17 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>11</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation... Farmer

11. Industry or business... _____

MOTHER FATHER

12. Name... John Getson

13. Birthplace... Unknown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name... Unknown

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

16. (a) Informant... Thomas Getson

(b) Address... Okean, Arkansas

17. (a) Removal (b) Date thereof... 3-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation... Hoxie, Arkansas

18. (a) Signature of funeral director... Albert H. Hoppe

(b) Address... 4700 Washington, Mo.

19. (a) FEB 28 1944 (Date received for registration)

J. F. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 497

(a) State... Arkansas (b) County... Randolph

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

(d) Street No... 0
(If rural, give location)

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

If yes, name country... 2.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27
year 1944 hour 7:55 minute P M.

21. I hereby certify that I attended the deceased from Feb 16 1944 to Feb 27 1944;
that I last saw him alive on Feb 24 1944
and that death occurred on the date and hour stated above.

Immediate cause of death... Hepatic insufficiency
Carcinoma of the liver(?)

Due to _____

Due to _____

Other conditions... Hof
(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) _____

(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... 0

23. Signature... M. C. Abner (M. D. or other)
Address... BARNES HOSPITAL
Date signed... 2/27/44

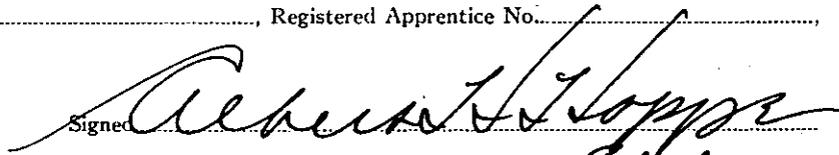
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 1861

P. O. Address.....

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.