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DEPARTMENT OF COMMERCE
MISSOURI ARCHIVES
FILED MAR 10 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8639

State File No. _____

Registration District No. 366

Primary Registration District No. 624/4536 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Washington (Breton Township)
(b) City or town Potosi Missouri
(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 16-7-9 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington
(c) City or town Potosi
(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

Morgan F. Lamarque

3. (b) If veteran, name war no 3. (c) Social Security No. 490-28-8161

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 July 9 1927
(Month) (Day) (Year)

8. AGE: Years 16 Months 7 Days 9 If less than one day hr. min.

9. Birthplace Potosi Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Garage helper

11. Industry or business _____

MOTHER FATHER { 12. Name James Lamarque
13. Birthplace Old Mines Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Martha Casey
15. Birthplace Blackwell Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James Lamarque
(b) Address Potosi Mo.

17. (a) Burial (b) Date thereof 2/21/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Potosi Mo.

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

(b) Address Potosi Mo.

19. (a) 2-19-1944 (b) Joseph L. Plummer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 18
year 1944 hour 5 minute A M.

21. I hereby certify that I attended the deceased from 2-16 1944 to 2-18 1944
that I last saw him alive on 2-17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Burns of lower extremities and right hand.
Due to gasoline.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 110
(b) Date of occurrence 2-16-1944
(c) Where did injury occur? Potosi Washington Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
auto garage

While at work? yes (Specify type of place) Means of injury Burns

23. Signature Joseph L. Plummer (M. D. or other)
Address Potosi, Mo. Date signed 2-19-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

District Health Officer No. 4
District File Number 244-3504
Date Filed 3-8-44

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 C. H. Boyd
Licensed Embalmer No. 4158
P. O. Address TOTOSI 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.

State File No.

Registration District No. 366

Primary Registration District No. (4536)

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Peters
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Morgan J. Lamagne

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race B

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 July 9
(Month) (Day) (Year)

8. AGE: Years 16 Months 2 Days _____ Unless than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) ms.

10. Usual occupation _____

11. Industry or business _____

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) Joseph L. Hovarian
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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?
Write at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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