

FILED APR 14 1944

Registration District No. 376

Primary Registration District No. 30606070

Registrar's No. 2

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

1. PLACE OF DEATH: St. Francois Co

(a) County St. Francois Co

(b) City or town Farmington, Mo RURAL

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. State hospital No. 1 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARIE MISKE (MISCHKE)

3. (b) If veteran, name war _____ 3. (c) Social Security No. Unknown

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced, Widow

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive, Dead years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years About 72 Months 72 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business None

12. Name Unknown

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

14. Maiden name Unknown

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

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

(b) Address Farmington, Missouri

17. (a) _____ (b) Date thereof 3-26-1944 (Burial, cremation, or removal) (City or town) (County) (State) (Month) (Day) (Year)

(c) Place: burial or cremation Old Dillard Cemetery

18. (a) Signature of funeral director Sheville

(b) Address Sheville

19. (a) 3-26-1944 (Date received local registrar) (b) James (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Missouri

(a) State Missouri (b) County Crawford 94

(c) City or town Dillard RURAL 0

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

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

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

If yes, name country Germany 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 25 year 1944 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from 2-26-44 to 3-25, 1944 at 3-24 or 3-24, 1944 that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Thronic Myocarditi Duration 1 yr +

Due to _____
Due to Senile Prostran 1 mo.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 93d
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 James (M. D. or other) 0
Address Farmington Mo Date signed 3/25/44

1375

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District Office No. 4
District File Number 444-37
Date Filed 4-12-48

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 L. J. Jones
....., Registered Apprentice No.
working under my personal supervision.

Signed L. J. Jones
Licensed Embalmer No. 2379
P. O. Address Shelville 9th

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.