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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 8 1944

Registration District No. _____

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3000

State File No. Bo 17247

Registrar's No. 123

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: A. S. O. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Three days. (Specify whether years, months or days)
In this community: Same as above

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Sullivan
(c) City or town: Milan, 105
(If outside city or town limits, write "RURAL")
(d) Street No. _____ 1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: Doctor Quinn Henry Becker
3. (b) If veteran, name war: No
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: Sarah Lucille Becker
6. (c) Age of husband or wife if alive: 36 years
7. Birth date of deceased: May 25, 1892 (Month) (Day) (Year)
8. AGE: Years 51 Months 11 Days 12 If less than one day: hr. min.
9. Birthplace: La Grange, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Osteopath Physician.
11. Industry or business: General Practice.
FATHER
12. Name: John A. Becker,
13. Birthplace: La Grange, Missouri (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Anna M. Quinn.
15. Birthplace: La Grange, Missouri (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Quinn H. Becker,
(b) Address: Milan, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 9, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: La Grange, Missouri
18. (a) Signature of funeral director: Schoepe Funeral Service
(b) Address: Milan, Mo.
19. (a) 5/11/44 (Date received local registrar) (b) Mrs. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 7. year: 1944 hour: 3:45 minute: P. M.
21. I hereby certify that I attended the deceased from May 4, 1944 to May 7, 1944 that I last saw him alive on May 7, 1944 and that death occurred on the date and hour stated above.
Immediate cause of death: Chronic syphilis — Duration
Due to: _____
Due to: _____
Other conditions (Include pregnancy within 3 months of death): 131 b
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: [illegible] (M. D. or other) D.O.
Address: Kirksville Date signed: 5-7-44

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-44-1055
Date Filed JUN 7 1944

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 Frank D. Schoen

Licensed Embalmer No. 2016

P. O. Address Milan, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.