

No. 2  
-8-43  
17-39

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19390

FILED JUN 12 1944

Registration District No. 8-6-367 Primary Registration District No. 6-1-8-4537 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Irondale  
(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 none  
(Specify whether \_\_\_\_\_)

In this community 254  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County WASHINGTON

(c) City or town IRONDALE  
(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 CHARLES HENRY QUEEN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 497-03-4810

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day March  
year 1944 hour 6 minute P.M.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife FLORA QUEEN

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Aug 15 1877  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-11, 1944 to 5-5, 1944  
that I last saw h. l. c. alive on 5-5, 1944  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>8</u>	<u>19</u>	hr. _____ min. _____

Immediate cause of death Cerebral artery occlusion  
since

Due to arterio-sclerosis

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

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 94a

10. Usual occupation MILLER

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business FLOUR MILL

12. Name LEWIS QUEEN

13. Birthplace OHIO  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name EMILY AKERS

15. Birthplace VIRGINIA  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant FLORA QUEEN

(b) Address IRONDALE

17. (a) Burial (b) Date thereof 5-7-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CONCORD CEMETERY

18. (a) Signature of funeral director J. S. Boyer

(b) Address Leadwood Mo

19. (a) 5-5-1944 (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

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 J. P. Geary (M. D. or other) \_\_\_\_\_  
Address Irondale Mo Date signed 5-6-44

RECEIVED

District Health Officer No. 4  
District File Number 644-3952  
Date Filed 6-9-44

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

*Bert L. Boyer*

Licensed Embalmer No. 3445

P. O. Address Leadwood 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.**

Registration District No. 367 Primary Registration District No. 4537

1. PLACE OF DEATH:  
(a) County Washington  
(b) City or town Independence  
(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 Charles H. Owen  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 11 1878  
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

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) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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 March Day 5 Year 1944 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 \_\_\_\_\_  
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? \_\_\_\_\_  
While 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.

Emily Hargrave  
(Registrar's Signature)

19390