

5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 31 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25569-72

State File No. _____

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr. 10 mos. 21
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne 94

(c) City or town Arab 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country D

3. (a) PRINT FULL NAME JOSEPH E. HASKETT

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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 About 1870
(Month) (Day) (Year)

8. AGE: Years About 74 Months _____ Days _____ If less than one day hr. _____ min.

9. Birthplace Wayne Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

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

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof June 8, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington, Mo.

18. (a) Signature of funeral director Berl J. Miller, Farmington, Mo.

(b) Address _____

19. (a) 6-15-44 (b) Jornack Robinson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5, year 1944 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 1, 1943 19____ to June 5, 1944 19____

that I last saw him alive on June 5, 1944 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism Duration _____

Due to fracture of left hip ✓

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy No autopsy.

22. If death was due to external causes, fill in the following: 1094

(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 1

23. Signature [Signature] (M. D. or other) 20

Address 408 W. [Address] Date signed 6-8-44

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

1373

(Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

RECEIVED

District Health Officer No. 4
District File Number 744-4104
Date Filed 7-28-44

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.....

Not Embalmed

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Carl J. Miller

Licensed Embalmer No. 3752

P. O. Address Farmington, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. aug
Registrar's No. _____

Registration District No. 316 Primary Registration District No. 6075

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Rural - St. Francois Aug
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph E. Heskett
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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ min.

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

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) _____ (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 _____ year 1964 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 cerebral embolism Duration _____

Due to fracture of hip
Due to _____

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

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) accident
(b) Date of occurrence 5-31-44
(c) Where did injury occur? Farmington - St. Francois - Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? State Hospital No. 4 on ward.
While at work? No (Specify type of place) (e) Means of injury Fell
23. Signature M. Langford (M. D. or other) mls
Address State Hospital No. 4, Date signed _____

Farmington, Mo.

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

SUPPLEMENTARY

25569