

FILED NOV 4 1944

State File No. _____

Registration District No. 160

Primary Registration District No. 30 29

Registrar's No. 128

1. PLACE OF DEATH

(a) County Jefferson

(b) City or town Crystal City
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

(c) City or town Crystal City
(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 Francis Paul Luther

3. (b) If veteran, name war _____

3. (c) Social Security 493-10-4479

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day tenth
year 1944 hour 10 A.M. minute _____ M.

4. Sex MO 5. Color or race W

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

(b) Name of husband or wife Neva Luther 6. (c) Age of husband or wife 26 years
alive _____ years

7. Birth date of deceased Nov 17 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 16 1944 to July 10 1944
that I last saw him alive on June 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____

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

35 7 23 hr. _____ min.

Due to nephritis ✓

Due to _____

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

10. Usual occupation Plumber

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

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name Ed. Luther

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

14. Maiden name Mary Emma Schirer

15. Birthplace St. Francois Co. MO
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Neva Luther

(b) Address Crystal City MO

17. (a) Burial (b) Date thereof 7-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roelawn Mem. Pk.

18. (a) Signature of funeral director Fink and Co.

(b) Address Fulus MO

19. (a) July 13 1944 (b) Silly Williams
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) no

(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. H. Williams (M. D. or other) DO

Address Fulus MO Date signed 7/12/44

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

RECEIVED

District Health Officer No. 97

District File Number _____

Date Filed 11-2-44

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 Eleanore Provice

Licensed Embalmer No. 3403

P. O. Address Festus 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. 160 Primary Registration District No. 3029

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Capital City
(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 Francis P. Luther

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 Nov. 17 1900
(Month) (Day) (Year)

8. AGE: Years 30 Months 7 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 July day 10 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 Cerebral hemorrhage Duration _____

Due to Nephritis Acute

Due to Acute Alkalosis

Other conditions _____ (Include pregnancy within 3 months of death) 8301

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION

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 F. L. M... M. D. or other

Address Capital Mo. Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN Underline the cause to which death should be charged statistically.

34528