

V. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40745

State File No. _____

FILED JAN 9 1945
Registration District No. 94 345

Primary Registration District No. 3007

Registrar's No. 390

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff Hoop
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County SHANNON 101
(c) City or town WINON 3
(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 _____

3. (a) PRINT FULL NAME GREEN C. Lancaster

20. DATE OF DEATH: Month DEC day 3
year 1944 hour 6 minute 45A M.

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

21. I hereby certify that I attended the deceased from Nov 22, 1944, to Dec 3, 1944
that I last saw h _____ alive on Dec 2, 1944
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death Cerebral Hemorrhage Duration Instant

7. Birth date of deceased: UNKNOWN
(Month) (Day) (Year)

8. AGE: Years About 82 Months _____ Days _____ If less than one day hr. _____ min. _____

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

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

Major findings: Of operations _____ Of autopsy _____

10. Usual occupation: FARMER

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? _____

11. Industry or business _____

12. Name: UNKNOWN

13. Birthplace: UNKNOWN (City, town, or county) (State or foreign country) 9

14. Maiden name: UNKNOWN

15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country) 9

16. (a) Informant: Paula Watts

(b) Address: Poplar Bluff Mo

17. (a) REMOVAL (b) Date thereof: 12-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: WINONA MO

18. (a) Signature of funeral director: Frank Cottrell

(b) Address: Poplar Bluff Mo

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

23. Signature: H. M. Herrick (M. D. or other) _____
Address: Poplar Bluff Mo Date signed _____

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

1273

RECEIVED

District Health Office No. 2

District File Number 145-41

Date Filed 1-5-45

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.....

Licensed Embalmer No. 29642

P. O. Address Poplar Bluff

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

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