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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 11 1945**  
Registration District No. 3616

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 6244

State File No. 10882  
Registrar's No. 18

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

**1. PLACE OF DEATH:**  
(a) County: Washington  
(b) City or town: Rural Union Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Shiloh Beth mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State: Mo. (b) County: Washington  
(c) City or town: Rural Union Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No.: Shiloh Beth mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME:** Charles Christensen  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month March day 24 year 1945 hour 10 minute 55 AM.  
**21. I hereby certify that I attended the deceased from** Mar 1 1945, to Mar 24 1945  
that I last saw him alive on Mar 1 1945  
and that death occurred on the date and hour stated above.

**4. Sex:** M **5. Color or race:** W  
**6. (a) Single, widowed, married, divorced:** Widow  
**6. (c) Age of husband or wife if alive:** \_\_\_\_\_ years  
**7. Birth date of deceased:** Sept 3 1860  
(Month) (Day) (Year)

Immediate cause of death: Malignancy of tongue and jaw.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

**8. AGE:** Years: 84 Months: 6 Days: 21 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**9. Birthplace:** Washington Co. Mo. (City, town, or county) (State or foreign country)  
**10. Usual occupation:** Miner  
**11. Industry or business:** \_\_\_\_\_

**MOTHER, FATHER**  
**12. Name:** Unknown  
**13. Birthplace:** Unknown (City, town, or county) (State or foreign country)  
**14. Maiden name:** Unknown  
**15. Birthplace:** Unknown (City, town, or county) (State or foreign country)

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

**16. (a) Informant:** James G. Hopkins  
**(b) Address:** Cadet mo RR. 1  
**17. (a) Place:** Burial **(b) Date thereof:** 3-26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

**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? \_\_\_\_\_

**18. (a) Signature of funeral director:** B. F. Sparker  
**(b) Address:** Potosi mo  
**19. (a) 3-24-1945** **(b) Joseph L. Plummer**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
**23. Signature:** Joseph L. Plummer (M.D. or other)  
**Address:** Potosi, Mo **Date signed:** 3-24-45

RECEIVED

District Health Officer No. 4

District File Number 445-489

Date Filed 4-10-45

*Not Embalmed*

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 *[Signature]*

Licensed Embalmer No. ~~44287~~

P. O. Address *[Signature]*

**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.**