

S. No. 2
FORM-2-43
Rev. 5-17-39
X35937

23627

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 13 1945
Registration District No. 33

Primary Registration District No. 3010

Registrar's No. 199

16
1
4
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU

(b) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1123 N. MIDDLE
(If not in hospital or institution, write street number or location)

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

In this community 2 YRS years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CAPE GIRARDEAU

(c) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL")

(d) Street No. 1123 N. MIDDLE
(If rural, give location)

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

3. (a) PRINT FULL NAME HENRY DALLAS ANGLE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race WH

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

6. (b) Name of husband or wife TABACCA ANGLE

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

7. Birth date of deceased MAY 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 10 If less than one day
hr. _____ min. _____

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

10. Usual occupation FARMER

11. Industry or business RETIRED

12. Name DON'T KNOW

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

14. Maiden name DON'T KNOW

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

16. (a) Informant D. COOK

(b) Address 1123 N. MIDDLE CITY

17. (a) BURIAL (b) Date thereof 7 5 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TAIRMONT

18. (a) Signature of funeral director PAUL HACKNEY

(b) Address CAPE GIRARDEAU MO

19. (a) 7-7-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 30th
year 1945 hour 7 minute — P.M.

21. I hereby certify that I attended the deceased from 1943
_____ 19____ to MAY _____ 19____
that I last saw him _____ alive on MAY 11 _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Hypertensive Paralysis

Duration _____

Due to _____

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) _____

(b) Date of occurrence _____

(c) Where did injury occur? at _____
(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) _____
Means of injury _____

23. Signature A. M. Murphy (M. D. or other) _____
Address Cap Girardeau Date signed 7-6-45

1014

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 845-968

Date Filed 8-10-45

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 *Paul Hackney*

Licensed Embalmer No. 3598

P. O. Address *Cape Girardeau 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.