

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED DEC 29 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Perry
(b) City or town Rural Cingue Homme
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: / July
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14-2-13 (Specify whether years, months or days)
In this community 14-2-13

3. (a) PRINT FULL NAME Alson Charles Unterreiner

3. (b) If veteran, name war. 3. (c) Social Security No. None

4. Sex Maled 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 September (Month) (Day) (Year)

8. AGE: 14 Years 2 Months 13 Days If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

12. Name Gilbert Unterreiner

13. Birthplace Perry Co. Missouri (City, town, or county) (State or foreign country)

14. Maiden name Lydia Moore

15. Birthplace Perry Co. Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Gilbert Unterreiner

(b) Address Perryville Mo. Star R.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Highland Mo.

18. (a) Signature of funeral director Harry R. Sons

(b) Address Perryville Mo.

19. (a) Mar 27, 1946 (Date received local registrar) (b) Joseph Zeller (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry
(c) City or town Rural (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 November day 25 year 1945 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from Nov 20 1945 to Nov 26 1945 that I last saw him alive on Nov 26 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Lobar Duration 6 Days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 O A Carron (M. D. or other)

Address Perryville Mo. Date signed 11-27-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 4
District File Number 1245-1455
Date Filed 12-26-45

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. 238

P. O. Address Payroll 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.