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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11853

FILED MAR 16 1946
319

Primary Registration District No. 4469

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Ste. Genevieve
(b) City or town Ste. Genevieve Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 HENRY LUX

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

4. Sex M Color or race W
5. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife DeLA CAMERON
6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased December 7 1861
(Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 10
If less than one day _____ hr. _____ min.

9. Birthplace Ste. Genevieve Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Fisherman

11. Industry or business F

12. Name Louis Lux

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

14. Maiden name MARY KAISER

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

16. (a) Informant William Camp

(b) Address Ste. Genevieve Mo

17. (a) BURIAL (b) Date thereof Feb 19 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve, Mo

18. (a) Signature of funeral director Jerome W. Benton

(b) Address Ste. Genevieve Mo

19. (a) 2-20-46 (b) Leo P. Karl
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ste. Genevieve
(c) City or town Ste. Genevieve Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 17
year 1946 hour 2 minute 1 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death ACUTE MYOCARDITIS

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 3

23. Signature Leo P. Karl (M.D. or other) _____

Address Ste. Genevieve Mo Date signed 2/18/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

550

(Licensed Embalmer's Statement on Reverse Side)

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..... *Jerome T. Scanton*

Licensed Embalmer No. *3817*

P. O. Address... *St. Genevieve, 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. *319*

Primary Registration District No. *4469*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Ste. Genevieve*

(b) City or town *Ste. Genevieve*
(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 *Henry Lux*

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 *div*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *Dec 1986*
(Month) (Day) (Year)

8. AGE: Years *84* Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation *Fisherman*

11. Industry or business *NONE*

MOTHER FATHER

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 *7* day _____ year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. _____ immediate cause of death.

Duration

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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) _____

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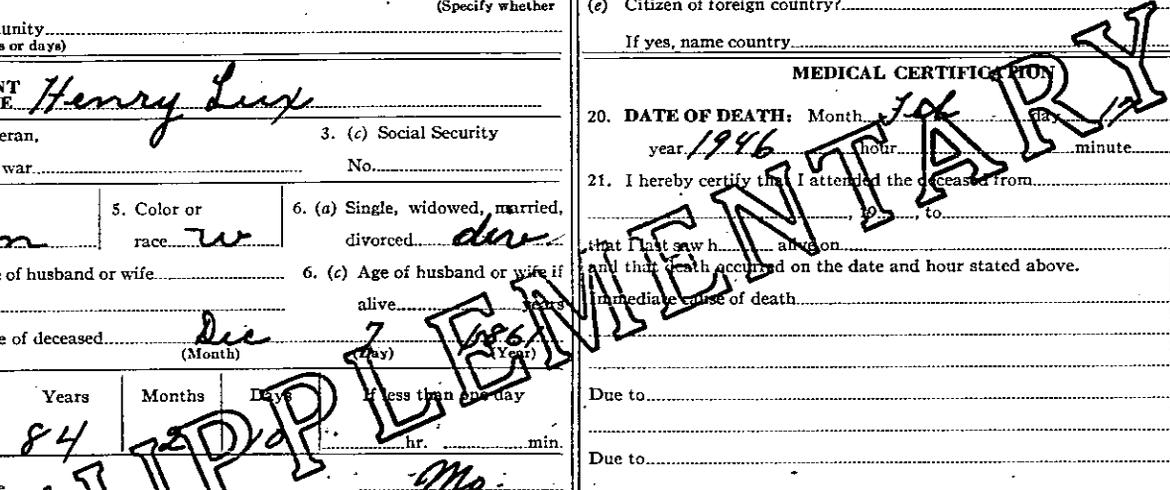
(c) Where did injury occur? _____ (City or town) (County) (State)

(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 _____ (M. D. or other) _____
Address _____ Date signed _____

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



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