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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12094

State File No.

FILED MAY 2 1946

Registration District No. 2

Primary Registration District No. 4007

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town Amazonia
(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 years, months or days)

In this community 2 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Benton 991

(c) City or town Bentonville 3
(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) 2

If yes, name country _____

3. (a) PRINT FULL NAME William Bryar Paine

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 10
year 1946 hour 9 minute 30 P.M.

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Grace M. Paine 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased: July 27 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 10, 1946 to April 10, 1946; that I last saw him alive on April 10, 1946; and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 8 Days 13 If less than one day _____ hr. _____ min.

Immediate cause of death carbolic acid poisoning Duration 2 hrs

Due to drinking carbolic acid; suicidal intent

Due to _____

9. Birthplace Kondrac, Wisconsin
(City, town, or county) (State or foreign country)

Other conditions none
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

Major findings: Of operations _____

Of autopsy carbolic acid poisoning

PHYSICIAN 163711

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER, FATHER { 12. Name Un Known

13. Birthplace un known 9
(City, town, or county) (State or foreign country)

14. Maiden name un known

15. Birthplace un known 9
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence April 10, 1946

(c) Where did injury occur? Amazonia, Andrew Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home
(Specify type of place)

16. (a) Informant Mrs Grace Paine

(b) Address Amazonia mo

17. (a) B (b) Date thereof 4-16-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation arcadia mt

While at work? _____ (Specify type of place)

(b) Means of injury _____

18. (a) Signature of funeral director E. C. Breet

(b) Address Savannah mo

19. (a) 4-15-46 (b) Leland Parks
(Date received local registrar) (Registrar's signature)

23. Signature Ralph Kelley (M. D. or other)

Address Savannah, Mo. Date signed 4/12/46

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(Licensed Embalmer's Statement on Reverse Side)

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

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..... *E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address. *Savannah Ga*

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.