

S. No. 2  
-12-45  
5-17-39  
P1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

File No. **21999**

FILED JUL 1 1947

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 209

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Flat River, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Bonnie Lewis Hospital S. 2 Mo. Co.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 2 days  
(Specify whether

In this community yes  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois <sup>94</sup>

(c) City or town Flat River, Mo. <sup>5</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 113 E. Main <sup>2</sup>  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) <sup>0</sup>

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mr. Clyde May

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5  
year 1947 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 1946, to June 5 1947  
that I last saw him alive on June 4 1947  
and that death occurred on the day and hour stated above.

4. Sex Male 5. Color or race White Cauc.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan. 17 1904  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day

43 4 18. hr. min.

9. Birthplace Flat River, Mo. (City, town, or county) (State or foreign country) <sup>0</sup>

10. Usual occupation Governor's Driver

11. Industry or business \_\_\_\_\_

12. Name Mr. George May

13. Birthplace Sheridan, Texas (City, town, or county) (State or foreign country) <sup>1</sup>

14. Maiden name Rosa Aberle

15. Birthplace Bonnie Lewis, Mo. (City, town, or county) (State or foreign country) <sup>0</sup>

16. (a) Informant Mrs. Rosa May Halter

(b) Address 113 East Main St. Flat River, Mo.

17. (a) Burial (b) Date thereof June 8 - 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Memorial Park

18. (a) Signature of funeral director Alvin W. Head

(b) Address 303 Crane St. Flat River, Mo.

19. (a) 6-23-47 (b) C. H. Cressler  
(Date received local registrar) (Registrar's signature) <sup>116</sup>

Major findings: Of operations 0

Of autopsy 0

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? (City or town) (County) (State) \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. H. Cressler (M. D. or other) <sup>116</sup>  
Address Flat River, Mo. Date signed 6-24-47

About 7:30 a. m. - June 4 - 1947. (Licensed Embalmer's Statement on Reverse Side)

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

4  
3  
1

RECEIVED

District Health Officer No. 4  
District File Number 647-880  
Date Filed 6-30-47

---

---

**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 Alain W. Hood  
Licensed Embalmer No. 2780  
P. O. Address 303 Crain St. Ft. Payne, 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.**