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1961

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS
FILED FEB 7 1948

Registration District No. 272

Primary Registration District No. 3908

Registrar's No. 144

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Holland rural
(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 2 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot 70

(c) City or town Holland rural
(If outside city or town limits, write "RURAL") 1

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? N (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Dave ~~John~~ Mege

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13
year 1948 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from Sept 1
1947 to Jan 1 1948
that I last saw him alive on Jan 1 1948
and that death occurred on the date and hour stated above. 1948

4. Sex M 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if 9
alive _____ years

7. Birth date of deceased Oct 1873
(Month) (Day) (Year)

Immediate cause of death Gen. condition
General Glaucoma - Ascidis
Myphitis

Due to	Duration
Due to _____	_____
Due to _____	_____

8. AGE: Years 74 Months 3 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation retired

11. Industry or business _____

MOTHER FATHER { 12. Name unknown 9

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

14. Maiden name unknown 9

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

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

Major findings: Of operations G2E

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant R.D. Ferguson

(b) Address Steele Rt. 1

17. (a) Burial (b) Date thereof 1-13-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt. Zion

18. (a) Signature of funeral director Wm. J. Bermon

(b) Address Steele 220

19. (a) 1-13-48 (b) W. J. Bermon
(Date received local registrar) (Registrar's signature) 2114

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 0

23. Signature W. J. Bermon (M. D. or other) MD

Address Steele Date signed 1-14-48

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

2-48-40

FEB 9 1948

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.....

not embalmed

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Fueh*Registration District No. *272*Primary Registration District No. *5908*Registrar's No. *144*

1. PLACE OF DEATH:

(a) County *Pemiscot*
(b) City or town *Rural*
(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 days3. (a) PRINT
FULL NAME *Dorel Megele*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 *wid*6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____7. Birth date of deceased *act 9*
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
hr. min9. Birthplace *Ind*
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *2-2-48* (b) *L. J. Robinson*
(Date received local registrar) (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 *Feb* Day *23*
Year *1948* Hour _____ minute _____ 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 _____

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

S-1961