DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 19 1949

THE STATE BOARD [redacted] MISSOURI
STANDARD CER[redacted]CATE OF DEATH

State File No. 42896

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 13

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Hickory Grove (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 days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Warren
(c) City or town Wright City Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Hickory Grove Twp.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Velma Georgia France
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓
4. Sex F. 3 5. Color or race Negro 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 Sept (Month) 13 (Day) 1928 (Year)

8. AGE: Years 20 Months 3 Days 4 If less than one day hr. min.

9. Birthplace Warren Co (City, town, or county) MO (State or foreign country)
10. Usual occupation Domestic work.
11. Industry or business
FATHER
12. Name George France
13. Birthplace St Charles Co (City, town, or county) MO (State or foreign country)
MOTHER
14. Maiden name Mabel Matthews
15. Birthplace Lincoln Co (City, town, or county) MO (State or foreign country)
16. (a) Informant Wardell Mal Moore
(b) Address 3608 Lake Park Chicago
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/48 (Month) (Day) (Year)
(c) Place: burial or cremation Wentzville Colored Cem
18. (a) Signature of funeral director Nelburg F & UA
(b) Address Wright City Mo.
19. (a) Jan 14 - 1949 (Date received local registrar) (b) Mrs. F. W. Hughes (Registrar's signature) 1 2 3 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18 year 1948 hour 7:30 minute P. M.
21. I hereby certify that I attended the deceased from Dec 15, 1948 to Dec 18, 1948; that I last saw her alive on Dec 15, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Acute General Miliary ~~Pulmonary~~ Tuberculosis	6 Mo.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature A. N. MacRae (M. D. or other) D.O.
Address Warrenton, Mo. Date signed 12/19/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9.
District File Number
JAN 18 1949
Date Filed
MAY 21 1957
OF HEALTH

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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 CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Fil

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Warren

(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Velma G. France

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 13 (Month) (Day) (Year)

8. AGE: Years 20 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

10. Usual occupation Domestic Work

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-42896