

FILED OCT 8 1949
60084-49

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31521**
Registrar's No. **348**

BIRTH NO. **124** REG. DIST. NO. **316** PRIMARY REG. DIST. NO. **3060**

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

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Francois	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River	9 ¹² 5 20
d. FULL NAME OF HOSPITAL OR INSTITUTION 1		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Carl	b. (Middle) Wayne	c. (Last) Jorhand	(Month) Sept	(Day) 12	(Year) 1949

5. SEX Male	6. COLOR OR RACE White-Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 12 - 1949	9. AGE (In years last birthday)	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min. 30
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Flat River, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Mothers said Raymond	13b. MOTHER'S MAIDEN NAME Norma Maxine Jorhand	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Norma Jorhand	ADDRESS Flat River, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity (5-6-1949)		INTERVAL BETWEEN ONSET AND DEATH 15 Min.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept. 12, 1949**, to **Sept. 12, 1949**, that I last saw the deceased alive on **Sept. 12 (8:15) 1949**, and that death occurred at **8:30 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Theodore Paul D.O.	23b. ADDRESS Flat River, Mo.	23c. DATE SIGNED 9/20/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 12 - 1949	24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	24d. LOCATION (City, town, or county) (State) Leadinton Mo.
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DATE REC'D BY LOCAL REG. Sept. 23, 1949	REGISTRAR'S SIGNATURE Ethel Rudlo	25. FUNERAL DIRECTOR'S SIGNATURE Alvin W. Hood	ADDRESS 303 Cass St. Flat River, Mo.
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RECEIVED 10-3-49

Health Officer No. 4

License Number 1049-13

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Alvin W. Hood

Signed _____
Student Embalmer

Licensed Embalmer No. 2780

P. O. Address 303 Crane St. Fall River, Ma

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.