S. No. 300
v. 10.48

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

FILED JAN 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2274

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY ST. FRANCOIS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BONNE TERRE
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BONNE TERRE HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY ST FRANCOIS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FARMINGTON 0941
d. STREET ADDRESS (If rural, give location) U

3. NAME OF DECEASED (Type or Print)
a. (First) MARY b. (Middle) BELLE c. (Last) ANTOINE

4. DATE OF DEATH (Month) January (Day) 7, (Year) 1951

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH SEPT. 15 1876
9. AGE (In years last birthday) 74 — If under 1 year: Months 3, Days 22 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BONNE TERRE, MO.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME MARTIN MURPHY
13b. MOTHER'S MAIDEN NAME MARY PATT.
14. NAME OF HUSBAND OR WIFE L.N ANTOINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME MRS. ORVAL CARROW **ADDRESS** FARMINGTON MO.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) — 331 X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-16, 1950, *to* 1-7, 1951, *that I last saw the deceased alive on* 1-6-, 1951, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) M.D.
23b. ADDRESS Farmington, Mo
23c. DATE SIGNED 1-8-51

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE JAN. 9 1951
24c. NAME OF CEMETERY OR CREMATORY OLD CALVARY
24d. LOCATION (City, town, or county) FARMINGTON (State) MO.

DATE REC'D BY LOCAL REG. Jan. 8, 1951
REGISTRAR'S SIGNATURE Esther Rudolph
25. FUNERAL DIRECTOR'S SIGNATURE O.B. Cozean **ADDRESS** Farmington Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed C A Cozean

Licensed Embalmer No. 4084

P. O. Address Farmington Me

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.