No. 2
5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 25546

FILED AUG 13 1943

Registration District No. 2054 Primary Registration District No. 3046 Registrar's No. 103

1. PLACE OF DEATH:
(a) County Montegue
(b) City or town Vi. Inland-Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Oldham Hospital
(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 all her Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montegue 68 0 0
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Elliott Deakins
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Lucinda Deakins
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept (Month) 7 (Day) 1853 (Year)

8. AGE: Years 89 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

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

MOTHER
14. Maiden name Lucinda Elliott
15. Birthplace Cooper (City, town, or county) Mo (State or foreign country)

16. (a) Informant Son William
(b) Address California Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-43 (Month) (Day) (Year)
(c) Place: burial or cremation Union Cemetery near James Boys

18. (a) Signature of funeral director Williams & Freeman
(b) Address California Mo

19. (a) 8-5-43 (Date received local registrar) (b) C G Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3 year 1943 hour 9 minute 2 M.

21. I hereby certify that I attended the deceased from Aug 3, 1943 to Aug 3, 1943 that I last saw him alive on Aug 2, 1943 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Lobar Pneumonia | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

108

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 D H Dawson (M. D. or other) D.O
Address California Date signed 8/5/43

1512

(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.....

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

working under my personal supervision.

Signed H. E. Friedmeyer

Licensed Embalmer No. 2854

P. O. Address California 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.**

No. 2B
—5-43

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. AUG 12 [illegible]

Registration District No. 224 Primary Registration District No. 3046 Registrar's No.

1. PLACE OF DEATH:
(a) County Montgomery Co Walker
(b) City or town California mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Latham Hospital
(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 mo. (b) County Montgom
(c) City or town Rural
(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 Wm Co. Deakins
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 7 (Day) 1863 (Year)

8. AGE: Years 84 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) mo. (State or foreign country)
10. Usual occupation
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) 8-4-43 (Date received local registrar) (b) R J Allee (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August 3 year 1943 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:
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-25546