

13-40  
7-39  
X23159

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 75

1. PLACE OF DEATH: St. Francois  
 (a) County St. Francois  
 (b) City or town St. Francois  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital No. 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 months  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME HENRY SPLITTOFF  
 3. (b) If veteran, name war Unknown  
 3. (c) Social Security No. None

4. Sex Male ( ) 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Sarah Foster  
 6. (c) Age of husband or wife if alive Unknown years  
 7. Birth date of deceased May 4th 1861  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	-	7	hr. _____ min.

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

10. Usual occupation Common Labor

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant State Hospital No. 4 Records

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 5-14-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Richardson's

(b) Address Farmington, Mo.

19. (a) 5-12-41 (b) T. J. Robinson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Madison  
 (c) City or town Marquand  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11th  
 year 1941 hour 10:30 P. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from March 11th, 1941, to May 11th, 1941,  
 that I last saw him alive on May 11th, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis & softening (several times)  
 Due to Senile psychosis  
type of senile psychosis  
General arteriosclerosis  
 Other conditions General arteriosclerosis  
 (Include pregnancy within 1 month of death)  
 Major findings: Of operations no  
 Of autopsy yes

Duration last day of death  
 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature T. J. Robinson (M. T. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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.....

*Patient 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.**