[...]MENT OF COMMERCE
[...]REAU OF THE CENSUS

# MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 3490

JAN 30 1942

Registration District No. 773 Primary Registration District No. 6020-A Registrar's No. 81

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre Mo (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 ___ In this community ___ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois
(c) City or town Bonne Terre (If outside city or town limits, write "RURAL")
(d) Street No. 13 Louise (If rural, give location)
(e) If foreign born, how long in U. S. A.? ___ years.

3. (a) PRINT FULL NAME LOGAN QUALLS
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 Married
6. (b) Name of husband or wife Della Qualls
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased March 5 1883 (Month) (Day) (Year)
8. AGE: Years 58 Months 8 Days 25 If less than one day ___ hr. ___ min.
9. Birthplace Murphysboro Illinois (City, town, or county) (State or foreign country)
10. Usual occupation Pipe Fitter
11. Industry or business
FATHER
12. Name John Qualls
13. Birthplace Illinois (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha Stevens
15. Birthplace Illinois (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs Della Qualls
(b) Address 13 Louise St Bonne Terre
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3. 1941 (Month) (Day) (Year)
(c) Place: burial or cremation B. T. Cemetery
18. (a) Signature of funeral director Bonne Terre [illegible] Co
(b) Address Bonne Terre Mo
19. (a) ___ (Date received local registrar) (b) ___ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30 year 1941 hour 11 minute 55 P. M.
21. I hereby certify that I attended the deceased from Nov 30, 1941, to Nov 30, 1941; that I last saw him alive on Nov 30, 1941, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Coronary Occlusion | |
| Due to Not Known | |
| Due to Had hypertension [illegible] years ago | |
| Other conditions Later normal (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 [illegible] (M.D. or other) DO
Address Bonne Terre Mo Date signed 12/6

(Licensed Embalmer's Statement on Reverse Side)

Rev. 8-17-39

District Health Officer No. 4
District File Number 142-68
Date Filed 1-13-42

## 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 C. J. Claywell

Licensed Embalmer No. 3706

P. O. Address Bonne Terre 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, above space should be left blank.**

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 3400

Registration District No. 775 Primary Registration District No. 6020-a Registrar's No.

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

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre (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 (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 Logan Qualls
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 Mar (Month) 5 (Day) 1883 (Year)
8. AGE: Years 58 Months 8 Days 25 If less than one day hr. min.
9. Birthplace (City, town, or county) (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) Dec-1-1941 (Date received local registrar) (b) Dr N W Hawkins (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 30 year 1941 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.
Immediate cause of death | Duration
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