V. S. No. 2
100M—5-43
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7027

State File No.

Registration District No. 3 10

Primary Registration District No. 305-9

Registrar's No. 299

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: Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hour
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(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 KASHER H. LUNSFORD

3. (b) If veteran, name war

3. (c) Social Security No. 488-16-5309

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Isabel Lunsford

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Jan (Month) 25 (Day) 1895 (Year)

8. AGE: Years 49 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Bonne Terre (City, town, or county) MO (State or foreign country)

10. Usual occupation Miner

11. Industry or business

MOTHER FATHER

12. Name Granville Lunsford

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

14. Maiden name Zelpha Haynes

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

16. (a) Informant Mrs. Isabell Lunsford

(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Parkview Cem. Farmington Mo.

18. (a) Signature of funeral director Miller Funeral Home

(b) Address Farmington, Mo

19. (a) 1-23-45 (Date received local registrar) (b) Bonnie D. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1945 hour 2 minute 30 A. 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. Verdict (Duration)

Immediate cause of death Due to injuries received by being struck by an automobile in an

Due to unavoidable accident

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) accident
(b) Date of occurrence January 21st, 1945
(c) Where did injury occur? Cleveland St. Francois, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway
(Specify type of place)
While at work? (e) Means of injury Coroner

23. Signature Ben J. Miller (M.D. or other)
Address Farmington, Mo Date signed 1/21/45

1373

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 245-250
Date Filed 2-20-45

MAR 2 1945

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 Burl J. Miller

Licensed Embalmer No. 3952

P. O. Address Farmington, 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.