

AUG 14 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26700

Registration District No. 775

Primary Registration District No. 6020-A

Registrar's No. 53

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: Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME

545 Sophie Van Alen

8. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife John C Van Alen

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

7. Birth date of deceased Nov 1 1872
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Ladies Clothing

12. Name Charles Papie

13. Birthplace French Village Mo
(City, town, or county) (State or foreign country)

14. Maiden name Justine Weik

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

16. (a) Informant's own signature Anna Buckle

(b) Address Bonne Terre Mo

17. (a) Burial (b) Date thereof July 14 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph's Cemetery

18. (a) Signature of funeral director Benjamin and Co

(b) Address Bonne Terre Mo

19. (a) July 14 1939 (b) N. W. Hawkins
(Date received local registrar) (Registrar's signature)

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. 307 Jackson
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1939 hour 1 minute 25 A.M.

21. I hereby certify that I attended the deceased from Dec 20, 1937, 19 _____, to July 12, 19 39; that I last saw him alive on July, 19 27; and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-vascular renal disease Duration 2 years

Due to 131

Due to _____

Other conditions Same
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy no 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.

Address Bonne Terre, Mo. Date signed 7-14-39

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.

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 Cornel Terie Md

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.