DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38394

FILED DEC 12 1945

Registration District No. 316 — Primary Registration District No. 3059 — Registrar's No. 239

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 2 days (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME John Gustau Joergensen
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 Singel
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 11 (Month) 2 (Day) 1883 (Year)

8. AGE: Years	Months	Days	If less than one day
62		23	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Peter Joergensen
13. Birthplace Denmark (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Kathern Mc Genus
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Earl Jones
(b) Address Esther Mo
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11 27 45 (Month) (Day) (Year)
(c) Place: burial or cremation Park View
18. (a) Signature of funeral director C. J. Bayer
(b) Address Desloge, Mo.
19. (a) 12-5-45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 25 year 45 hour 1 minute 45 P.M.
21. I hereby certify that I attended the deceased from Nov 23, 19 45, to Nov 25, 19 45, that I last saw him alive on Nov. 11 45, 19 45, and that death occurred on the date and hour stated above.

Duration
Immediate cause of death Lobar Pneumonia — 1 day
Due to Fracture of Left Hip — 3 days
Due to A fole — ✓
Other conditions (Include pregnancy within 3 months of death) — ✓
Major findings: Of operations — ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED ✓
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 C. Chitten M.D. (M. D. or other)
Address Ellen St. Bonne Terre Mo Date signed Dec 27, 1945.

1397 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 1245-14

Date Filed 12-10-45

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 D. T. Dwyer

Licensed Embalmer No. 3660

P. O. Address Klamath Falls

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.

S. No. 2B
25M—3-45
I X43880

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

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STANDARD CERTIFICATE OF DEATH

State File No. Dec*

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 239

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 years, months or days)
In this community

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 John . G. Jorgensen
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 2 1882 (Month) (Day) (Year)

8. AGE: Years 62 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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28 year 1944 hour 1 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 Lobar Pneumonia	2 days.
Due to Fracture of Left Femoral Neck.	4 days.
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

SUPPLEMENTARY INFORMATION REQUESTED 12-15

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 Nov. 28
(c) Where did injury occur? Flat Rock (City or town) Mo. (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? No (e) Means of injury Fall

23. Signature C E Sutton (M. D. or other)
Address 11 Elm St. Bonne Terre Mo Date signed 12/19/44

38394