

REC'D NOV 5 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36993
Do not use this space.

1. PLACE OF DEATH *Stoddard*
 (a) County *Stoddard* Registration District No. *837*
 (b) Township *Stoddard* Primary Registration District No. *6089* Registered No. _____
 (c) City *Marion* (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Stella Sands*
 (a) Residence, No. *1/2 mile N.W. - Marion, Mo.* St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Child*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Child*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May - 1936*

7. AGE YEARS *2* MONTHS *-* DAYS *-* If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Child*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Child*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *1 mi west of Tanner, Mo.*

FATHER
 13. NAME *Chas. Sands*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

MOTHER
 15. MAIDEN NAME *Lina Gung*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

17. INFORMANT (ADDRESS) *Chas Sands Marion, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Marion, Mo.* DATE *Oct 12, 1938*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Andrew Ellis Sikeston, Mo.*

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 20, 1938*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 28 - 1938*, to *Sept 30, 1938*
 I last saw her alive on *Oct 30 - 1938* Death is said to have occurred on the date stated above, at *5 P.M.*
 The principal cause of death and related causes of importance were as follows:
Depletion
 Date of onset _____

Other contributory causes of importance: *10*

Name of operation _____ Date of _____
 What test confirmed diagnosis? *Cholera* Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) *A. A. Mayfield*, M. D.
 (Address) *Sikeston, Mo.*

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.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

36998
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 837
 (b) Township Castor Primary Registration District No. 6097 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Stella Lands
 (a) Residence, No. 1 1/2 mi. n. W. merchandise rd (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1 1936
 7. AGE YEARS 2 MONTHS 4 DAY - If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 17m West of Jasper, Mo
 13. NAME Chas Lands
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
 15. MAIDEN NAME Sina E. Lands
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
 17. INFORMANT (ADDRESS) Chas Lands merchandise rd
 18. BURIAL, CREMATION, OR REMOVAL PLACE Funeral Home - Supt. Oct 1 1938
 19. FUNERAL DIRECTOR (ADDRESS) Arthur Ellinger Sikeston Mo
 20. FILED Dec. 19 1938 Loone Purich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 30 1938
 22. I HEREBY CERTIFY, That I attended deceased from Sept 28 to Sept 30, 1938
 I last saw her alive on Sept 30, 1938. Death is said to have occurred on the date stated above, at 5 P. m.
 The principal cause of death and related causes of importance were as follows:
Dysentery
 Date of onset _____
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) A. J. Mayfield, M. D.
 (Address) Sikeston Mo

WRITE PLAINLY, WITH UNFAADING INK--THIS IS 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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