

REC'D JAN 24 1939

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

3229  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 245  
(b) Township Big Prairie Primary Registration District No. 5800 Registered No. \_\_\_\_\_  
(c) City Matthews, P.O. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(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 Mary Mars

(a) Residence, No. RFD 2 Matthews, 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 4, 1939 19

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Widow of Frank Mars, Decd.

22. I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1938, 19, to Dec. 28, 1938, 19.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. or wife on Dec. 28, 1938 Death is said to have occurred on the date stated above, at 4:45 m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 4 hrs. or 1 min. 74 yrs. not known

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Domestic  
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) Death  
11. Total time (years) spent in this occupation Life

Pneumonia, bronchal, severe cold and symptoms of influenza; infirmities of age.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Memphis, Tenn.

Other contributory causes of importance: As above: Aged, infirm

13. NAME Unknown (Supposed to be Jackson)

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Mary Jackson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Silas Martin

18. BURIAL, CREMATION, OR REMOVAL PLACE Portageville Mo. DATE 1/6/1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Delisle Funeral Home  
Portageville, Mo.

20. FILED Portageville, Mo. Local Registrar.

Name of operation ---none--- Date of \_\_\_\_\_  
What test confirmed diagnosis? --- Was there an autopsy? no

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. never

Manner of injury ---  
Nature of injury ---

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) J. G. Martin, M. D.  
(Address) Sikeston, Mo.

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**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 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  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3029

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 340  
(b) Township Big Prairie Primary Registration District No. 5800 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(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 Mary mare

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-4, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.,

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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 \_\_\_\_\_

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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 J. F. Waters M. D.

(Signed) Director (Address) mo

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Apr 4 1937 Mildred N. Deane Local Registrar

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

