

DEC 10 APR 10 1939

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

10333
Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 121
 (b) Township Cape Girardeau Primary Registration District No. 2009
 (c) City Cape Girardeau (d) Street No. St. Francis Hospital Registered No. 113
 (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 5/10 3 Lelair Maynard
 (a) Residence, No. Bell City, Mo. St. Bell City Mo.
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED
 (OR) WIFE OF W. T. Maynard
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 9, 1884
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
54 8 15
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Missouri
 FATHER 13. NAME Pink Phillips
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 MOTHER 15. MAIDEN NAME Sarah Smith
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee
 17. INFORMANT Clarence Maynard
 (ADDRESS) Advance Mo. R. F. D.
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Pleasant Grove DATE March 26, 1939
 19. FUNERAL DIRECTOR (NAME) Chiles Und. Co.
 (ADDRESS) Bloomfield, Mo.
 20. FILED 3-24-39 J. M. Thompson
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24, 1939
 22. I HEREBY CERTIFY, That I attended deceased from Mar 16, 1939, to Mar 24, 1939
 I last saw her alive on Mar 24, 1939 Death is said to have occurred on the date stated above, at 11.45 A.M.
 The principal cause of death and related causes of importance were as follows:
Pneumococcal Meningitis 3/22/39 Date of onset 3/22/39
 Other contributory causes of importance:
Pleurocytotoxic Effusion 3/1/39
Pneumonia in January 1939
 Name of operation None Date of.....
 What test confirmed diagnosis? None 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? No
 If so, specify George B. Shalkey M. D.
 (Signed) George B. Shalkey (Address) Cape Girardeau 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.

79

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.

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
DIVISION OF ANATOMY AND EMBALMING

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10333
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125
 (b) Township _____ Primary Registration District No. 3009 Registered No. _____
 (c) City Cape Girardeau (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 Le Clair Maynard

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-24-39

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 54 8 15

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. _____
 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) _____ * Total time (years) spent in this occupation _____

Pneumococic meningitis
110
 Date of onset 2/22/39

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

Other contributory causes of importance:
Pleurisy with effusion
Pneumonia in situ
 Date of death 3/11/39

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____

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 Geo. H. Walker, M. D.
 (Address) Cape Girardeau

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION MUST BE PROPERLY CLASSIFIED. SO THAT IT MAY BE PROPERLY CLASSIFIED.

This is a true and correct copy of the original as filed in the office of the Registrar of Deaths in plain terms, so that it may be properly classified. Exact statement of occupation must be properly classified. So that it may be properly classified.

MAY - 2 1964