

WRITE PLAINLY, WITH UNFADING 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.

REC'D APR 10 1939

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

Do not use this space.

11674

1. PLACE OF DEATH *New Madrid 2*
 72 County *Corn* Registration District No. *605*
 Township *Corn* Primary Registration District No. *4359*
 City (No. _____) St. _____ Ward _____

2. FULL NAME *Mrs. Blanch Theresa Dubois*
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr 3, 1893*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>45</i>	<i>11</i>	<i>28</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*

9. Industry or business in which work was done, as silk mill, 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) *Mo*

FATHER

13. NAME *Samuel Mansfield*

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

MOTHER

15. MAIDEN NAME *unknown*

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

17. INFORMANT *Phillip Dubois*
(ADDRESS) *Rivers Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Sikeston* DATE _____ 19____

19. UNDERTAKER *Ellise General Co*
(ADDRESS) *Sikeston Mo*

20. FILED *3/6* 19 *39* *Dr. Elwood Hustler*
Registrar. *534*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 6*, 19 *39*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 3*, 19 *38*, to *Mar 6*, 19 *39*.
 I last saw her alive on *Oct 7*, 19 *39*. Death is said to have occurred on the date stated above, at *8 A.* m.
 The principal cause of death and related causes of importance were as follows:
Hemorrhage of uterus
45
 Other contributory causes of importance:
Carcinoma

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

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) *Elwood Hustler*, M. D.
 (Address) *Parsons, Mo*

