

APR 7 1939

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

11683
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 604
 (b) Township New Madrid Primary Registration District No. 5807 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

(a) Residence, No. X (Usual place of abode, if no street address, write county or city) St. (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 (write the word) Married

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14, 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>70</u>	<u>8</u>	<u>18</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeping

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) 1938

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid Co Missouri

FATHER 13. NAME Candy Pagan

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

MOTHER 15. MAIDEN NAME Mary sister of

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

17. INFORMANT (ADDRESS) J. W. Perkins

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE May 5 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm O Bannan

20. FILED 3/27 1939 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4 1939

22. I HEREBY CERTIFY, That I attended deceased from 3/3, 1939 to 3/4, 1939. I last saw her alive on 3/4, 1939. Death is said to have occurred on the date stated above, at 3:30 p.m. The principal cause of death and related causes of importance were as follows:
III Congestive Heart Failure

Date of onset 3/3/39

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) Wm O Bannan, M. D. (Address) New Madrid

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.

Look

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.

STATEMENT BY LICENSED EMBALMER

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

11683
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 604
 (b) Township New Madrid Primary Registration District No. 3802
 (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 Sarah Ann Perkins

(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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marcel
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-14-1864
 7. AGE YEARS 70 MONTHS 8 DAYS 18 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. N
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4, 1939
 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:
Coronary Heart Failure
Chronic Myocarditis
 Other contributory causes of importance: 93C
 Date of onset 3/3/39

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)
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____
 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 _____
 (Signed) Wm. M. Johnson, M. D.
 (Address) New Madrid, Mo

Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S OCCUPATION should be stated EXACTLY. 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.

SUPPLEMENTAL

MAY - 7 1939