

1939 APR 25 1939

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

11925
Do not use this space.

1. PLACE OF DEATH *Pike* ^{nr} Registration District No. *689*
 (a) County *Pike* 1
 (b) Town or City ~~_____~~ Primary Registration District No. *3035* Registered No. _____
 (c) City *Louisiana* (d) Street No. *City House 2800 Georgia* 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 *Mrs Susana Birchfield*
 (a) Residence, No. *City House 2800 Georgia* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *George Birchfield*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1/28-1960*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *79 1 19*
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *None*
 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) *W. Va.* _____
 FATHER 13. NAME *Mr J O'Brien* _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *(?)* _____
 MOTHER 15. MAIDEN NAME *Susan (?)* _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *(?)* _____
 17. INFORMANT (ADDRESS) *Mrs Ollie (Mrs Geo) Calvin Louisiana Mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Overseer* DATE *March 18, 1939*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. H. Hays Louisiana Mo*
 20. FILED *3/17 1939 J. H. Hays* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-17-1939*
 22. I HEREBY CERTIFY, That I attended deceased from *3-10* 19*39*, to *3-17* 19*39*
 I last saw h. w. alive on *3/14* 19*39*. Death is said to have occurred on the date stated above, at *8:15 A.M.*
 The principal cause of death and related causes of importance were as follows:
Pulmonary Tuberculosis Date of onset _____
 Other contributory causes of importance: *22*
 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) *J. M. Keason*, M. D.
 (Address) *Louisiana Mo* *1620*

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.

RECEIVED

District Health Officer No. 10

District File Number 10-39-664

Date Filed APR 17 1939

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.