

REC'D JUN 22 1939

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

19312
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605
(b) Township Cairo Primary Registration District No. 4359 Registered No.
(c) City Cairo MO (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 ELZENA S. HEARD

(a) Residence, No. Cairo MO 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Calvin Sheard
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 7, 1902
7. AGE YEARS 36 MONTHS 5 DAYS ✓ If LESS than 1 day, hrs. or min.
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) West Point Miss

FATHER 13. NAME Willie Hale
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Point Miss

MOTHER 15. MAIDEN NAME Emilie Hale
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Point Miss

17. INFORMANT Bessie Hale
(ADDRESS) Cairo MO18. BURIAL, CREMATION, OR REMOVAL
PLACE Box Farm DATE May 8, 3919. FUNERAL DIRECTOR (NAME) (ADDRESS) J. H. Wright
531
Paris MO20. FILED 5/8 1939 D. Stewart
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1939, to May 7, 1939
I last saw h. or alive on May 1, 1939. Death is said to have occurred on the date stated above, at 10.9 m.
The principal cause of death and related causes of importance were as follows:

Anesthetic dysentery Date of onset
12 W

Other contributory causes of importance:

Name of operation Chol Date of no
What test confirmed diagnosis Chol 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.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify Cholera M. D.
(Signed) Parma
(Address) Parma

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.