

23399
Do not use this space.

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

23399

Do not use this space.

1. PLACE OF DEATH

(a) County Scott Registration District No. 821
(b) Township Richland Primary Registration District No. 4553
(c) City Sikeston (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

(a) Residence, No. _____ St. _____
(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 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 Mamie D. Wilburn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-12-1866

7. AGE YEARS 72 MONTHS 11 DAYS 20 IF LESS THAN 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as law mill, bank, etc. Farming
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) Metropolis Illinois

FATHER 13. NAME Benjamin F. Wilburn

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

MOTHER 15. MAIDEN NAME Sarah Holloway

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

17. INFORMANT (ADDRESS) Mamie Wilburn Patton, Mo. R#1

18. BURIAL, CREMATION, OR REMOVAL PLACE Sikeston RFD DATE 7-2 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hunter Albritton Sikeston, Mo.

20. FILED 7-10 1939 W. H. Prarell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-1-39

22. I HEREBY CERTIFY, That I attended deceased from 6-4 1939 to 7-1-39. I last saw him alive on 7-1-39. Death is said to have occurred on the date stated above, at 7 A.M.

The principal cause of death and related causes of importance were as follows:

Left Cerebral Thrombosis Date of onset 4-1-39
Terminal Bronchopneumonia 6-18-39
Ess. Hypertension 1-1-39

Other contributory causes of importance: 826

Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: No
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: _____
(Signed) Meslin S. Anderson M. D.
(Address) Sikeston, 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.

RECEIVED

District Health Officer No. 2,

District File Number 239-64

Date Filed 7-12

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.