

DESD AUG 9 1939

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

Do not use this space.

26346

1. PLACE OF DEATH

County New Madrid Registration District No. 607
Township Portage Primary Registration District No. 5806
City 260 Alberta (No. Tices) St. _____ Ward _____

2. FULL NAME

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hubert Tices

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May-4-1905

7. AGE YEARS 35 MONTHS 2 DAYS ✓ IF LESS than 1 day, _____ hrs. or _____ min.

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) Hollywood (STATE OR COUNTRY) Miss 1

13. NAME Will Bynum 1

14. BIRTHPLACE (CITY OR TOWN) N.C. (STATE OR COUNTRY) 9

15. MAIDEN NAME No history

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

17. INFORMANT Hubert Tices (ADDRESS) Portageville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Portageville DATE 7/14-39

19. UNDERTAKER W. J. ... (ADDRESS) Portageville, Mo.

20. FILED 7-31 19 39 Mary W. Cook Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from June 27, 1939, to July 3, 1939. I last saw him alive on June 27, 1939. Death is said to have occurred on the date stated above, at 9 a.m.

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

Coronary Thrombosis

Other contributory causes of importance: 94

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) H. J. ... M. D.

535 (Address) Portageville 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 839-121

Date Filed 8-4

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

26346

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 607
(b) Township Partage Primary Registration District No. 3806
(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. (?) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 46

2. PRINT FULL NAME Alberta Tice

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-3, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 4 - 1905

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DMS If LESS than 1 day, _____ hrs. or _____ min.
31 7 29

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

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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 _____

Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

Other contributory causes of importance: _____

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 7-31, 1939 Mary W. Cook Local Registrar

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) H. T. O'Kelley, M. D.
(Address) Partageville Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 26346

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community years, months or days

3. (a) PRINT FULL NAME Alberta Ticer

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive.

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years: Months: Days: If less than one day min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name. 13. Birthplace (City, town, or county) (State or foreign country) 14. Maiden name. 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1939 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to No Pregnancy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94 Of autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify). (b) Date of occurrence. (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.

23. Signature H. J. Kelly (M. D. or other) Address Portageville Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY