

REC'D AUG 23 1939

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

26982  
Do not use this space.

1. PLACE OF DEATH  
(a) County Scott Registration District No. 821  
(b) Township..... Primary Registration District No. 4553  
(c) City Sikeston, Mo. or (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 Eliza Haley  
(a) Residence, No. Sikeston, Mo. 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 7 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 W.C. Haley  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 19, 1888  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 56 3 14  
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. Housewife  
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) Aug. 3, 1939  
22. I HEREBY CERTIFY, That I attended deceased from July 5, 1939 to Aug 3, 1939  
I first saw him alive on July 5, 1939 Death is said to have occurred on the date stated above, at 10:15 P.M.  
The principal cause of death and related causes of importance were as follows:  
Tuberculosis  
Date of onset about 6 yrs ago

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
13. NAME ? Allen  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
15. MAIDEN NAME Uhlenow  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ✓  
17. INFORMANT W. C. Haley (ADDRESS) Sikeston, Mo.  
18. BURIAL, CREMATION OR REMOVAL PLACE McMullen, Mo. DATE Aug, 4, 1939  
19. FUNERAL DIRECTOR (NAME) Arden Ellis (ADDRESS) Sikeston Mo.  
20. FILED Aug 18, 1939 W. H. Orrell Local Registrar.

Other contributory causes of importance:  
80  
Name of operation..... Date of.....  
What test confirmed diagnosis? clinical 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 Howard M. Kendig, M. D.  
(Signed) W. H. Orrell (Address) Sikeston Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

110  
11  
2

*Kendrick*

RECEIVED

District Health Officer No. 22,

District File Number

839-162

Date Filed

8-22

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, on Aug. 3,

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Arden Ellis

Licensed Embalmer No. \_\_\_\_\_

3869

P. O. Address \_\_\_\_\_

Weston, N.C.

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.