

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.

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

28762
Do not use this space.

REC'D SEP 20 1939

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125
 (b) Township _____ Primary Registration District No. 3009 Registered No. 291
 (c) City Cape Girardeau (d) Street No. South East Mo. Hospital 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. (If nonresident, give city or town and State)
Bobby Gene Sides

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 17, 1931
 7. AGE YEARS 8 MONTHS 3 DAYS 4 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 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) Leeman Mo (STATE OR COUNTRY) _____

FATHER 13. NAME Norman B. Sides
 14. BIRTHPLACE (CITY OR TOWN) Leeman Mo (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Delphia Creach
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

17. INFORMANT Norman H. Sides (ADDRESS) Leeman Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE pleasant Hill DATE Aug 23 1939

19. FUNERAL DIRECTOR (NAME) Macre-Wilson-Statler (ADDRESS) Jackson Mo

20. FILED 8-21 1939 J. M. Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-21 1939
 22. I HEREBY CERTIFY, That I attended deceased from 8-10 1939 to 8-21 1939.
 I last saw him alive on 8-21 1939 Death is said to have occurred on the date stated above, at 5:00 p.m.
 The principal cause of death and related causes of importance were as follows:

Meningitis
(Spinal meningitis)
not isolated
 Date of onset 1 week
 Other contributory causes of importance: 79 W

Name of operation none Date of _____
 What test confirmed diagnosis? Spinal P. 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? No
 If so, specify _____ (Signed) D. R. DeLoach M. D.
 (Address) Jackson, Mo

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

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,

by me

or by

Registered Apprentice No., working under my personal supervision.

Signed

Glenn Wilson

Licensed Embalmer No.

2828

P. O. Address

JACKSON MO

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.