

Dr. Sam Martin

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29719

SEP 13 1939
Registration District No. 122

Primary Registration District No. 4334

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie
(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 _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Stillborn, Cora Mae

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

4. Sex female 5. Color or race W. 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased August 5 1937
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day none
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Hodges Allen

18. Birthplace Abing, Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Couch

15. Birthplace Silerton, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hodges Allen

(b) Address East Prairie, Mo.

17. (a) Burial (b) Date thereof 8 3 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W.O.W. East Prairie

18. (a) Signature of funeral director Samuel

(b) Address East Prairie, Mo.

19. (a) Sept 5 39 (b) Dr. Sam Martin
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miss.

(c) City or town East Prairie Mo.
(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 Aug 5 1939
Month Aug day 5
year hour minute M.

21. I hereby certify that I attended the deceased from Aug 5 1939 to Aug 5 1939
that I last saw alive on Aug 5 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Stillborn

Due to Jaundice 7th Mo

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Dr. Sam Martin (M. D. or other) _____
Address East Prairie Date signed 7/4/39

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 939-208

Date Filed 9-11

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.