

OCT 13 1939

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

33073  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605  
 (b) Township Cairo Primary Registration District No. 4359  
 (c) City Cairo (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 Opal E. Roe

(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

3. SEX F 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 Glyde Roe  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 31 1909  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 30 5 16  
 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. Housewife  
 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) Malden Mo.  
 FATHER 13. NAME Arthur L. Black  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cairo Ill.  
 MOTHER 15. MAIDEN NAME Mary Johnson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carrollton Ill.  
 17. INFORMANT (ADDRESS) Mable Dry (Sister) Malden, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Malden Mo. DATE Sept-18 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) M. C. Craig Malden Mo.  
 20. FILED Sept 17 1939 St. Louis, Mo. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept-17 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Sept 1 1939 to Sept 17 1939  
 I last saw her alive on Sept 17 1939 Death is said to have occurred on the date stated above, at 7:30 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Labor Pneumonia  
 Date of onset Sept 16 1939  
 Other contributory causes of importance: \_\_\_\_\_  
 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) E. E. Jones, M. D.  
 (Address) 5700 Hillbourn, 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.

Dr. J. E. Jones, Hillbourn, Mo.

RECEIVED

District Health Officer No. 2,  
District File Number 1639-289  
Date Filed 10-16

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, ~~John~~.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*L.H. Craig*

Licensed Embalmer No.....

*2850*

P. O. Address.....

*Malden 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.