

Registration District No. **59** **OCT 10 1939**

Primary Registration District No. **4388**

Registrar's No. **92**

1. PLACE OF DEATH:
(a) County **Pemiscot**
(b) City or town **Weatherlyville**
(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) **153** **Days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** County **Pemiscot**
(b) City or town **Weatherlyville**
(c) Street No. **409 1/2 13th St**
(d) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Missouri's ...**
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **9** day **23**
year **1939** hour **11-46** minute **0** mt.

4. Sex **Female** 5. Color or race **col**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **8-8-1884**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept. 22 - 1939** to **Sept. 23**, 19**39**
that I last saw her alive on **Sept. 22 - 1939**
and that death occurred on the date and hour stated above.

8. AGE: Years **55** Months **1** Days **15** If less than one day
hr. _____ min. _____

Immediate cause of death **Cerebral Hemorrhage** Duration **1 day**

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

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation **house keeping**
11. Industry or business _____
12. Name **Anderson Nalden**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **W. H.**
15. Birthplace **11-11** (City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Mary Bates**
(b) Address **Memphis**
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation **Morgan Ruff Cemetery**
18. (a) Signature of funeral director _____
(b) Address **Weatherlyville, Mo.**
19. (a) **Sept 30 1939** (Date received local registrar) (b) **Ada Martin** (Registrar's signature)

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 **J. R. Pison** (M. D. or other) _____
Address **Weatherlyville, Mo.** Date signed **9-23-39**

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. USE WRITING BLACK INK—MAKE A PERMANENT RECORD.

RECEIVED

District Health Officer No. 2

District File No. 1039-52

Date 10/5/39

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 *H. S. Smith*

Licensed Embalmer No.....

P. O. Address *Cynthiana 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33149
Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 651
(b) Township Caruthersville Primary Registration District No. 4388 Registered No.
(c) City Caruthersville 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 Missouri Curvin

(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 7 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wid)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 1 15

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) (STATE OR COUNTRY) unknown

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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 Jan. 84 1940 Aida Mantis Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-23, 1937

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

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

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

Cerebral Hemorrhage Date of onset

Other contributory causes of importance:

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 J. R. Quinn, M. D.

(Address) Caruthersville Mo

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SUPPLEMENTARY

