DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 1 - 1939

Registration District No. 284

# MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 39502

Primary Registration District No. 4173

Registrar's No. 41

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Malden
(If outside city or town limits, write "RURAL" and name of township)
(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
In this community 75 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Malden,
(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.

3. (a) PRINT FULL NAME MARY ALEXANDRIA
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race Wht.
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Jerry Rice
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 19 (Day) 1857 (Year)

8. AGE: Years 82 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Carter Co. Ky (City, town, or county) (State or foreign country)
10. Usual occupation Retired Housekeeper
11. Industry or business

FATHER
12. Name Fleming A Alexandria
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rebecca Pope
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs B. Rafford
(b) Address Malden Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-28-'39 (Month) (Day) (Year)
(c) Place: burial or cremation Malden Mo.
18. (a) Signature of funeral director N.L. Craig
(b) Address Malden Mo.
19. (a) 11/28/39 (Date received by local registrar) (b) L.E. Mitchell (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27
year 1939 hour 3 minute 10 P.M.
21. I hereby certify that I attended the deceased from Nov. 17, 1939, to Nov. 27, 1939, that I last saw her alive on November 26, 1939 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death End Arteritis obliterans | 10 days |
| Due to Unknown. | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Homer Bell (M. D. or other)
Address Malden Mo Date signed 11/28/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 8-17-39 1 x10511

RECEIVED
District Health Officer No. 3,
District File Number 1239-709
Date Filed 12/8/39

**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, [redacted], Registered Apprentice No. ....., working under my personal supervision.

Signed Van H. Grange

Licensed Embalmer No. 2850

P. O. Address Malden

**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

39502
Do not use this space.

1. PLACE OF DEATH
(a) County Dunklin Registration District No. 289
(b) Township Malden Primary Registration District No. 4173 Registered No. 41
(c) City ..... (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 Mary Alexander correct,
(a) Residence, No. ..... St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| F | W | Wid |

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

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

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 82 | 6 | 8 | |

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) (STATE OR COUNTRY)

FATHER
13. NAME Flemming Alexandria
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
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 1/11 19 40 S E Mitchell Local Registrar.

SUPPLEMENTARY

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 27 1939

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

| | 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 .....
(Signed) Homer Beall, M. D.
(Address) Malden Mo