

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.

Registration District No. 607

Primary Registration District No. 4361

Registrar's No. 61

1. PLACE OF DEATH:

(a) County New Madrid 2
(b) City or town Portageville
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Ella White Dean 560

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 Married

6. (f) Name of husband or wife _____ 6. (e) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 44 Months 1 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name George Wallace

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

14. Maiden name Mary Estes

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

16. (a) Informant's own signature Pete Welsh

(b) Address Portageville, Mo

17. (a) _____ (b) Date thereof 11 20 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Portageville, Mo

18. (a) Signature of funeral director R.M. Payne

(b) Address Portageville, Mo

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature) SSS

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 1
(c) City or town _____ (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: Month Nov day 19th year 1939 hour 7:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from Nov. 12, 1939, to Nov 19, 1939; that I last saw her alive on Nov 18, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Chronic Nephritis 3da 2 yrs

Due to _____

Other conditions Chr. Myocarditis ? (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no 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 John J. Killian (M. D. or other) !
Address Portageville, Mo Date signed 11-21-39

Duration

3da

2 yrs

?

PHYSICIAN

Underline the cause to which death should be charged statistically

Closed
4/40 P.M.
Dean.

RECEIVED

District Health Officer No. 2.

District File Number 1287-383

Date Filed 12-4

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.

2B
21-40
X2285

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40346

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 607

Primary Registration District No. 4361

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. *New Madrid*

(b) City or town. *Portageville*
(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..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME *Ella white*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *7*

5. Color or race *W*

6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife. *Symon white*

6. (c) Age of husband, or wife, if alive.....

7. Birth date of deceased. *Oct 6 1899*
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<i>44</i>	<i>1</i>	<i>13</i>min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *Nov. 30 1939* (b) *Mary W. Corte*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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.

20. DATE OF DEATH: Month *Nov* day *19*
year *1939* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

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?
..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature *John J. Killian* (M. D. or other).....

Address *Portageville Mo.* Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

