

Registration District No. 20 DEC 25 1939 Primary Registration District No. 821-4553 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Boyer Co.
(b) City or town Sikeston, Mo.
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
() years, months or days

3. (a) PRINT FULL NAME Charity Thomas
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race negr 6. (a) Single, widowed, married, divorced
6. (b) Name of husband as wife Link Thomas 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Centron 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Esterson

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

14. Maiden name Esterson

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

16. (a) Informant's own signature Charity Thomas

(b) Address Sikeston, Mo.

17. (a) _____ (b) Date thereof Nov 19, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation See Sat add.

18. (a) Signature of funeral director Charles Ellis

(b) Address Sikeston, Mo.

19. (a) 12-21-1939 (b) W. H. Phillips
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boyer
(c) City or town Sikeston (If outside city or town limits, write "RURAL")
(d) Street No. Highway 25 (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15 year 1939 hour 8:15 minute _____ M.

21. I hereby certify that I attended the deceased from 15 past Nov 15, 1939, to _____, 1939; that I last saw him alive on Nov 15 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

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? _____

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

23. Signature W. H. Phillips (M. D. or other) _____

Address Sikeston, Mo. Date signed Nov 16

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WHILE FAMILIAR 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.

I X1051

23

RECEIVED
MAY 10 1964
STATE OF MICHIGAN
DEPARTMENT OF HEALTH

RECEIVED

Michigan Health Officer No. 2,
File Number 1239-454
Date 12-26

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 N. [Signature]
....., Registered Apprentice No.
working under my personal supervision.

Signed John Ellie
Licensed Embalmer No. 3869
P. O. Address St. Joseph, Mich.

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

40953
Do not use this space.

1. PLACE OF DEATH

(a) County Scott Registration District No. 821
 (b) Township Sireston Primary Registration District No. 4523
 (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 Charity Thomas

(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 Negro 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.
79

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)

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 _____, 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15, 1939

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:

Tuberculosis of lungs.

Date of onset

Other contributory causes of importance: 23

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. M. Waters, M. D.

(Address) Sireston, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 N. B.—Every item of information 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.

