DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6186

Registration District No. 121 Primary Registration District No. 3009 Registrar's No. 55

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southeast Mo Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir.

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Maggie May Hutson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Willie Hutson

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

7. Birth date of deceased February (Month) 18 (Day) 1882 (Year)

8. AGE: Years 57 Months 11 Days 17 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John Welker
13. Birthplace Daisy (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Arah Crites
15. Birthplace Daisy (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Willie Welker

(b) Address Cape Girardeau Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb (Month) 5 (Day) 40 (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Mache Wilson Statler

(b) Address Jackson Mo

19. (a) 2-4-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 4 year 1940 hour 7 30 a.m. minute — M.

21. I hereby certify that I attended the deceased from 1-15-40, 19__, to 2-4-40, 1940 that I last saw her alive on 2-3-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-vascular renal disease	2 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 D. R. Seabaugh (M. D. or other) Med

Address Jackson, Mo Date signed 2-4-40

(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.

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. Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address. Jackson 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.