

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAR 1 1940

Registration District No. 829m

Primary Registration District No. 5801

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rural  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural  
(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 Dorris May Kersey

8. (b) If veteran, name war \_\_\_\_\_

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 22  
year 1940 hour 3 minute 5 P. M.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 2 22 1938  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-22, 1940, to 2-22, 1940  
that I last saw h alive on 2-22, 1940  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>2</u>	<u>0</u>	<u>0</u>	hr. _____ min. _____

Immediate cause of death Pneumonia

Due to Acute Toxicities

Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name David Kersey

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

14. Maiden name Lina Asher

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Joseph Asher

(b) Address Charter Oak Mo.

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? \_\_\_\_\_

(c) Place: burial or cremation Matthews Mo.

18. (a) Signature of funeral director Wm. W. Whitton

(b) Address Sikeston Mo.

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

19. (a) 3-8-1940 (b) W. W. Whitton  
(Date received local registrar) (Registrar's signature)

23. Signature W. W. Whitton (M. D. or other) \_\_\_\_\_

Address Sikeston - Mo Date signed 2-23-40

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.

RECEIVED

District Health Officer No. 2.

District File Number 340-742

Date Filed 3/11/40

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**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 Hunter Albritton

Licensed Embalmer No. 2940

P. O. Address Bickston Me

**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.