

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7537**

MAR 12 1940

Registration District No. **607** Primary Registration District No. **5306** Registrar's No. _____

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Portageville
(c) Name of hospital or institution Rural District - Portageville Mo
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Twenty years (Specify whether years, months or days)

8. (a) PRINT FULL NAME Maggie Sidel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Henry Sidel 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased (Month) 8 (Day) 9 (Year) 1908

8. AGE: Years 31 Months 5 Days 22 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Joe Edgar }
13. Birthplace Miss (State or foreign country)

14. Maiden name Abena Sidel
15. Birthplace Miss (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary W. Cook
(b) Address Portageville, Mo

17. (a) Burial (b) Date thereof Mar 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

✓(c) Place: burial or cremation Burial - Portageville Cemetery

18. (a) Signature of funeral director R. M. Payne
(b) Address Portageville, Mo 535

19. (a) Mar 7 1940 (b) Mary W. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Portageville, Mo
(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 March day 3rd year 1940 hour 1 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Feb 21, 1940 to Mar 2, 40, 19____ that I last saw her alive on Mar 2, 40, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Influenza and Pneumonia

Due to _____
Due to HA

Other conditions (Include pregnancy within 3 months of death) One month prior to 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? _____

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

23. Signature A. D. Reeder (M. D. or other) _____
Address Portageville, Mo Date signed 3/12/40

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 - 5

Date Filed 3/11/

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7537**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **607**

Primary Registration District No. **3806**

Registrar's No.

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Paragage**
(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..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Maggie Tiedel**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or **negro** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased **8** **8** **1905**
(Month) (Day) (Year)

8. AGE: Years **31** Months **5** Days **25** If less than one day
..... hr. 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) **Mar. 7, 1940** (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Mar** day **3**
year **1940** hour..... minute..... M.

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

Duration

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?

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

23. Signature **A. A. Reeder** (M. D. or other).....

Address **Paragage** Date signed.....

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

SUPPLEMENTARY

