

Registration District No. 821Primary Registration District No. 6070

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston, Mo. Rfd. 1
(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 L. Junior Alexander 425

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased January 8 1940
(Month) (Day) (Year)8. AGE: Years _____ Months 2 Days 26 If less than one day _____
hr. _____ min. _____9. Birthplace Walnut Miss
(City, town, or county) (State or foreign country)10. Usual occupation Infant

11. Industry or business _____

12. Name Claude Alexander13. Birthplace Falkner Miss
(City, town, or county) (State or foreign country)14. Maiden name Healen Alexander15. Birthplace Walnut Miss
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Claude Alexander(b) Address Sikeston Mo. Rfd. 117. (a) burial (b) Date thereof April 4, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memullin Mo.18. (a) Signature of funeral director John Albritton(b) Address Sikeston, Mo.19. (a) 5-10-1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott(c) City or town Sikeston, Mo. Rfd. 1
(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 April day 3rd
year 1940 hour 12:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from

Apr 2, 1940, to Apr 3, 1940
that I last saw him alive on Apr 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Broncho Pneumonia Duration _____

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 [Signature] (M. D. or other) _____Address [Address] Date signed 4-4-40

1072

RECEIVED

District Health Officer No: 2

District File Number 540-10

Date Filed 5/15/49

Junior was the full given name

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.....

not embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed

John G. Gentry

Licensed Embalmer No.

2941

P. O. Address

St. Louis

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *16206*

Registration District No. *821*

Primary Registration District No. *6070*

Registrar's No.

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

1. PLACE OF DEATH:

(a) County *Scott*

(b) City or town *Richland T.P.*
(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) (Specify whether

3. (a) PRINT FULL NAME *Alexander Junior*

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

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

4. Sex *m*

5. Color or race *col*

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

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

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

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

8. AGE:	Years	Months	Days	If less than one day
		<i>2</i>	<i>26</i>	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)..... (b)..... (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 *Apr* day *3* year *1946* hour..... minute..... M.

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

Immediate cause of death *Broncho pneumonia*

Due to *No history of measles or whooping cough*

Due to *I saw patient day before death. All symptoms of Broncho pneumonia*

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

Major findings: Of operations.....

Of autopsy.....

107W

Duration

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 *J.A. Mayfield* (M, D, or other).....

Address *Director* Date signed.....

SUPPLEMENTAL

