

STANDARD CERTIFICATE OF DEATH

State File No. **16307**

FILED MAY 17 1940

839
10101

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Sikeston Mo - R#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 3 years
(Specify whether

In this community 3 years
years, months or days)

8. (a) PRINT FULL NAME Narcie Elizabeth Jamerson

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 Widow

6. (b) Name of husband or wife Moses A. Jamerson 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased Oct 2 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 18 If less than one day
hr. min.

9. Birthplace Livingston Co. Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER { 12. Name Nat. Newsley
13. Birthplace Fayette Co Ky
14. Maiden name Agnes Kingler
15. Birthplace Fayette Co Ky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm B Sumner

(b) Address R#1 Sikeston Mo

17. (a) Crema (b) Date thereof 3-21-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cremated

18. (a) Signature of funeral director John Smith

(b) Address Sikeston Mo

19. (a) (Date received local registrar) (b) 15/11 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard
(c) City or town Sikeston Mo - R#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 Mar day 20th
year 1940 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from 3-18, 1940, to 3-20, 1940,
that I last saw her alive on 3-18, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia +
Cardiac Failure

Duration 3 weeks

Due to Typhoid injection

Due to

Other conditions Osteo Pelvic
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations
Of autopsy

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 A. M. Jones M.D. (M. D. or other)
Address Wheeler Mo. Date signed 3-20-40

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RECEIVED

District Health Officer No.

District File Number 540-106

Date Filed 5/15/4

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 A. Sutton

Licensed Embalmer No. 2941

P. O. Address Sikeston 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16307

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Stoddard
(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)

3. (a) PRINT FULL NAME

NANCIE ELIZABETH JAMERSON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced old

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 73 Months 5 Days 18 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)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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.

REGISTRATION CERTIFICATION

20. DATE OF DEATH Month Mar day 20
year _____ 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 Septicemia Duration _____

cardiac failure

Due to leg infection

Due to varicose ulcers

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

1000

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 S.M. Sarno (M. D. or other) _____

Address Morehouse Ins Date signed _____

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16307

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town Rickland, 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)

3. (a) PRINT FULL NAME

Narcie Elizabeth Emerson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years 73

Months 5-

Days 8

If less than one day

h. 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

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20
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 _____

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 S. M. James (M. D. or other) _____

Address warehouse Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY