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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22359
State File No.

Registration District No. 604

Primary Registration District No. 4358

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(c) Name of hospital or institution: No
(d) Length of stay: In hospital or institution No
In this community 235
years, months or days

3. (a) PRINT FULL NAME ESTELLA ROSTON
(b) If veteran, name war No
(c) Social Security No. No

4. Sex FEMALE
5. Color or race COLORED
6. (a) Single, widowed, married, divorced MARRIED
(b) Name of husband or wife BOOKER T. ROSTON
(c) Age of husband or wife if alive 38 years
7. Birth date of deceased Feb 18-1905
(Month) (Day) (Year)

8. AGE: Years 35 Months 4 Days 26
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business No

MOTHER FATHER { 12. Name Wm PARROT
13. Birthplace New Madrid, Mo.
14. Maiden name Ada Young
15. Birthplace New Madrid, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Booker T. Roston
(b) Address New Madrid

17. (a) Burial (b) Date thereof July 18-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sand Hill

18. (a) Signature of funeral director Richardson & Co
(b) Address New Madrid, Mo.

19. (a) 7/16/1940 (b) Wm O. Bauman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town New Madrid
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1940 hour 11:55 minute AM

21. I hereby certify that I attended the deceased from _____, 19____, to 7-14, 1940
that I last saw her alive on 7-14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Premature separation of Placenta at 7 mo gestation - Underage -
Duration 1 day
Due to Fall day before on 7-13-40
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 533
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature L. P. Edmundson (M. D. or other) 1
Address New Madrid Date signed 7-16-40

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

144B

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. **22359**
Registrar's No. **1**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **604**

Primary Registration District No. **4328**

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

1. PLACE OF DEATH:
(a) County **New Madrid**
(b) City or town **New Madrid**
(If outside the 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.....
In this community..... (Specify whether years, months or days)

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

4. Sex **7** 5. Color or race **col** 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..... (Month) (Day) (Year)

8. AGE: Years **35** Months **4** Days **26** 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) (Burial, cremation, or removal) (b) Date thereof..... (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.

20. DATE OF DEATH: month **July** day **14** year **1940** 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.

22. 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 **Premature separation of placenta at 7 months pregnancy**
semorrhage
Due to **fall day before on 7-13-1940**
Other conditions (Include pregnancy within 3 months of death) **1940**
Major findings: **Baby delivered 10% AP. 141**
Of operations: **(Y.O. abortion) Shovli about 12⁰⁰ Mon.**
Of autopsy: **Separation of Placenta about 10⁰⁰ AM.**

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 **D. P. Edmondson** (Name or other).....
Address **New Madrid**.....

Duration
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

