

15 1940

Registration District No. 651

Primary Registration District No. 4388

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Peru
(b) City or town Caruthersville
(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 years, months or days) 5 yrs - 1 day

8. (a) PRINT FULL NAME Joanna Robinson

3. (b) If veteran, name war ✓ 8. (c) Social Security No. none

4. Sex Female 5. Color or race col 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased 2-17-1894
(Month) (Day) (Year)

8. AGE: Years 46 Months 3 Days 14 If less than one day _____ br. _____ min.

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

10. Usual occupation House work

11. Industry or business _____

12. Name Don't know

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

14. Maiden name Mary M. E. Entwistle

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Rudie Stoker

(b) Address Caruthersville Mo

17. (a) Burial (b) Date thereof 6-2-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morgan Ridge Church

18. (a) Signature of funeral director H. S. Smith

(b) Address Caruthersville Mo

19. (a) June 7, 1940 (b) Ceda Martin
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Peru
(c) City or town Caruthersville
(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 May day 31
year 1940 hour 14-50 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 1, 1940 to May 1, 1940
that I last saw her alive on 5-1-1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage

Due to Hypertension

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? _____

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

23. Signature D. J. Aquino (M. D. or other) _____

Address Caruthersville, Mo Date signed 6-4-40

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

7-40-16

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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 Noel C. Dean

Licensed Embalmer No. 3941

P. O. Address Caruthersville

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.

S. No. 2B
M-2-21-40
I 23859

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22474
Registrar's No. 57

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 657

Primary Registration District No. 4388

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

1. PLACE OF DEATH:
(a) County Pemissot
(b) City or town Pamthersville
(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 John Pasmore
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 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 46 Months 3 Days 14 If less than one day..... 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) Oct. 4, 1940 (b) Ada Maiten
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
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 May day 31
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..... 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.....

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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

