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P. 1 X21492

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

Throgmorton

Registration District No. **566** Primary Registration District No. **5764**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Bertrand Mo. R.F.D.# 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 _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Lorene Magee

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 _____

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

7. Birth date of deceased 34 8 40
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 29 _____ hr. _____ min.

9. Birthplace Bertrand R.F.D.# 1 Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Elisha Magee

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

14. Maiden name Bunav Williams

15. Birthplace Middle Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Elisha Magee

(b) Address Bertrand MO. R.F.D.# 1

17. (a) Burial (b) Date thereof 7/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director J. S. Garrison
(b) Address Sikeston Mo.

19. (a) _____ (b) F. S. Garrison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Bertrand 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 7 day 7
year 1940 hour 5 minute 10 a.m.

21. I hereby certify that I attended the deceased from June 29
1940 to July 7 1940
that I last saw her alive on July 4 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Alta Colicilitis +
mausmus

Due to _____

Due to _____

Other conditions Premature Infant
(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 J. S. Garrison (M. D. or other) _____

Address Sikeston, MO Date signed 7-10-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 2

District File Number 840-130

Date filed 8/7/40

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 O'Leary

Licensed Embalmer No. 2941

P. O. Address Like ton

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. 25-759

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 266

Primary Registration District No. 5764

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Long Prairie, 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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Lorene makee

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 -

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 Months Days If less than one day
2 29 _____ 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) Sept 11th 40 (b) J. J. Johnson
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 7
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 _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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