

Registration District No. 603

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid County
(b) City or town Catron
(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 Rebecca Coleman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race negro 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased Oct 19 1938
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 9 3 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Tom Coleman

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

14. Maiden name Georgia May Brown

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

16. (a) Informant's own signature Tom Coleman

(b) Address Catron

17. (a) Catron, Mo (b) Date thereof 7-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W. H. ...
(b) Address _____

19. (a) 7-16-40 (b) Dr. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Catron
(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 July day 16
year 1940 hour 3 minute 30 M.

21. I hereby certify that I attended the deceased from July 16
1940, to July 16, 1940;
that I last saw her alive on July 16, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Poison from fly toxin

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) Accidental homicide

(b) Date of occurrence July 16-40

(c) Where did injury occur? Catron Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At home - child drank fly poison
(Specify type of place) (e) Means of injury _____

23. Signature Geo W. ... (M. D. or other) _____

Address Paris Date signed 7/16/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.