

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29808

State File No. _____

Presnell
Registration District No. 821

Primary Registration District No. 4553
Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days 5 2 10

8. (a) PRINT FULL NAME Thomas Jefferson Lancaster

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

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

7. Birth date of deceased 10 7 1858
(Month) (Day) (Year)

8. AGE: Years 81 Months 10 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name Enich Lancaster

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

14. Maiden name Powell

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

16. (a) Informant's own signature Prata Stubblefield

(b) Address Sikeston Mo. 815 Matthews Ave.

17. (a) Burial (b) Date thereof 8/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director John Albritton

(b) Address Sikeston Mo.

19. (a) 9-9-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Sikeston Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 815 Matthews Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 22
year 1940 hour 3 minute _____ PM.

21. I hereby certify that I attended the deceased from April 16
1940, 1940 to Aug 22, 1940
that I last saw him alive on Aug 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart Disease, Chronic

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 8 months of death)

Major findings:
Of operations _____

Of autopsy no

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 [Signature] (M. D. or other) _____

Address Sikeston Mo Date signed 8-22-40

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.

RECEIVED

District Health Officer No.

District File Number 940-145

Date Filed 9/10/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

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.