

FILED OCT 18 1948

Registration District No. 282

Primary Registration District No. 4675402

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Buffalo Rural
(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 _____
years, months or days

3. (a) PRINT FULL NAME Novelle Joell Wilkins
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race White 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 July 9 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 12 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER
12. Name Novelle Wilkins
13. Birthplace Buffalo Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Arbusta Goodrich
15. Birthplace Buffalo Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address _____

17. (a) Burial (b) Date thereof July 22
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director McDaniel Funeral Service

(b) Address Beulah

19. (a) 7-24-40 (b) W. W. English
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Rural
(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 21
year 1940 hour 7:35 minute _____ A. M.

21. I hereby certify that I attended the deceased from 7-9-40
_____, 19____, to 7-21, 1940
that I last saw h. or alive on 7-20, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis
Due to Impetigo
Due to _____

Other conditions Mother had a very
(Include pregnancy within 3 months of death) swollen throat & a mild nephritis

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? _____

(Specify type of place) _____
While at work (e) Means of injury _____
23. Signature W. W. English (M. D. or other) _____
Address Cardwell Date signed 8-1-40

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.

RECEIVED

District Health Officer No. 2

District File Number 1040-1491

Date Filed 10/1/40

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.....

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.