

Registration District No. **607**

Primary Registration District No. **5806**

Registrar's No. **48**

**1. PLACE OF DEATH:**

(a) County **New Madrid**  
 (b) City or town **Portageville, Mo.**  
 (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 **20**  
 (Specify whether years, months or days)  
 In this community \_\_\_\_\_

3. (a) PRINT FULL NAME **Samuel Isabelle**

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

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **infant**

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

7. Birth date of deceased **Sept 10 1939**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<b>8</b>	hr. _____ min. _____

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **Clarence Isbell**

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

14. Maiden name **Martha Huffman**

15. Birthplace **Madison, Mo.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Sam Isbell**

(b) Address **Portageville, Mo.**

17. (a) \_\_\_\_\_ (b) Date thereof **9-18-1940**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Portageville**

18. (a) Signature of funeral director **R.M. Carmel**

(b) Address **Portageville, Mo.**

19. (a) **9-18-40** (b) **Mary W. Cook**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo.** (b) County **New Madrid**  
 (c) City or town **Portageville, Mo.**  
 (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 **9** day **18**  
 year **1940** hour **3** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **9-8**, 19**40**, to **9-18**, 19**40**  
 that I last saw him alive on **9-16**, 19**40**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia** **1wk**  
 Due to **Malnutrition** **2mo**  
 Due to **Dysentery** **2wk**  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration  
 1wk  
 2mo  
 2wk  
**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?  
**535** (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **John Villison** (M. D. or other) \_\_\_\_\_  
 Address **Portageville, Mo.** Date signed **9-18-40**

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

RECEIVED

District Health Officer No. 2

District No. Number 1040-15

Date Recd. 10/3/40

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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.....

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.**