

17-39
I X237

NOV 20 1940
Registration District No. 65-1

Primary Registration District No. 4388

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Caruthersville
(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 2
(Specify whether
In this community 30 yrs
years, months or days)

3. (a) PRINT FULL NAME Mary Bernett

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race B 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive ✓ years _____
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years about 66 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework ?

11. Industry or business Home

MOTHER FATHER { 12. Name unknown 9
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 Wood Jones

(b) Address Hwy 270

17. (a) Burial (b) Date thereof 10-2-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maxon Ridge

18. (a) Signature of funeral director H. R. Smith General

(b) Address Caruthersville Mo

19. (a) Oct. 19, 1940 (b) Uda Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot
(c) City or town Caruthersville
(If outside city or town limits, write "RURAL")
(d) Street No. West ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 1
year 40 hour 11 minute 1 M.

21. I hereby certify that I attended the deceased from May
1939 to Oct 1st 1940
that I last saw h _____ alive on Oct 4th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Intest / Nephritis & Myocarditis
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration
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?
_____ (Specify type of place)
While at work? 505 (e) Means of injury _____

23. Signature W. B. Lutz (M. D. or other) _____
Address Caruthersville Mo Date signed 10/2/40

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

8

11-40-11

18286

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35957**
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **657**

Primary Registration District No. **4388**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Peru**
(b) City or town **Caruthersville**
(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

Mary Bennett

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F**

5. Color or race **B**

6. (a) Single, widowed, married, divorced **wid**

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

abt 66

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **1**
year **1946** 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

**Acute, Intermittent
Nephritis - mys
Carditis**

Due to **Chronic Nephritis**

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

