

No. X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FEB 4 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2464

Registration District No. 289

Primary Registration District No. 4173

Registrar's No. 5

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

1. PLACE OF DEATH:  
(a) County Dunklin  
(b) City or town Malden  
(c) Name of hospital or institution: 1  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County Dunklin  
(c) City or town Malden  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

In this community \_\_\_\_\_ years, months or days)  
3. (a) PRINT FULL NAME Elizabeth Anderson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 10  
year 1941 hour 10 minute 28 9pm

4. Sex H. 5. Color or race W. 6. (a) Single, widowed, married, divorced 2  
6. (b) Name of husband or wife J. R. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 28 - 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 10 to Jan 10, 1941  
that I last saw her alive on Jan 10 and that death occurred on the date and hour stated above.  
Immediate cause of death Chronic Arthritis

8. AGE: Years 76 Months 2 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Includes pregnancy within 3 months of death) 5 1/2

9. Birthplace Dyer Co. Tenn!  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name John Ray  
13. Birthplace Tenn!  
(City, town, or county) (State or foreign country)  
14. Maiden name Louise McBlenshan  
15. Birthplace Tenn!  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Mary Carter  
(b) Address Malden Mo  
17. (a) Burial (b) Date thereof Jan. 12-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Malden

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? 267

18. (a) Signature of funeral director W. R. Craig  
(b) Address Malden  
19. (a) 1-10-41 (b) Smithell  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Cause of injury)  
23. Signature J. E. Mitchell (M. D. or other) MD  
Address Malden Mo Date signed 1/14/41

RECEIVED

District Health Officer No. 2

District File Number 241-157

Date Filed 2/6/41

STATE OF ILLINOIS  
DEPARTMENT OF HEALTH

**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.**

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Registration District No. 289

Primary Registration District No. 4173

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Malden  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME Elizabeth Anderson

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

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

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

7. Birth date of deceased Oct - 28 - 1864  
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

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) 3/29/1941 (b) J. E. Mitchell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 10  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I have seen him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature J. E. Mitchell (M. D. or other) \_\_\_\_\_

Address Malden Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

