

APR 15 1941

State File No. _____

Registration District No. 274

Primary Registration District No. 4062

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Lilbourn Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution no
In this community About 3 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

IREN FALL

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

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

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

7. Birth date of deceased About 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 73 hr. min.

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

10. Usual occupation Housewife

11. Industry or business unk.

MOTHER FATHER { 12. Name: unk.
13. Birthplace: unk. 9
(City, town, or county) (State or foreign country)
14. Maiden name: unk.
15. Birthplace: unk. 9
(City, town, or county) (State or foreign country)

16. (a) Informant Myra Cook

(b) Address Lilbourn Mo.

17. (a) Burial (b) Date thereof March 3-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sanct Hill

18. (a) Signature of funeral director R. H. Jones

(b) Address New Madrid Mo.

19. (a) Mar 3/41 (b) E. E. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Lilbourn Mo. 99
(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 March day 2
year 1941 hour 5:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him alive on 2-25- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Paralysis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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? _____

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

23. Signature E. E. Jones (M. D. or other) ✓

Address Lilbourn Mo Date signed 3-3-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

272

52A

RECEIVED

District Health Officer No. _____

District File Number 441-4

Date Filed 4/11/44

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 Leo Hudgrett

Licensed Embalmer No. 3803

P. O. Address New Madrid 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.

Registration District No. 274

Primary Registration District No. 4063

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Litbourn
(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

Jean Tall

3. (b) If veteran, name _____

3. (c) Social Security No. _____

4. Sex F

5. Color col

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

abk 73

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) _____

(Date received local registrar)

(b) _____

(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2
year 1987 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 paralysis Duration _____

Due to Cerebral hemorrhage

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 12w

Major findings:
Of operations _____

Of autopsy _____

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? _____ (e) Means of injury _____

23. Signature J N Wilson (M. D. or other) _____
Address Litbourn Mo Date signed 6-7-41

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

SUPPLEMENTARY

11464