

APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11465

State File No. _____

Registration District No. 24Primary Registration District No. 4063

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid Co Mo
(b) City or town Lilbourn M
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Non
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community Born Here (Specify whether
years, months or days) 1

8. (a) PRINT FULL NAME Rosie Lee McCray3. (b) If veteran, name war No 3. (c) Social Security No. No4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced S 06. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years7. Birth date of deceased Mar I 1941
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
X X 29 hr. min.9. Birthplace Catron, Mo. 0
(City, town, or county) (State or foreign country)10. Usual occupation Non11. Industry or business Non

MOTHER FATHER
12. Name Charlie McCray
13. Birthplace Mc Comb City Miss 1
(City, town, or county) (State or foreign country)
14. Maiden name Ruthie Graham
15. Birthplace Forest City Ark 1
(City, town, or county) (State or foreign country)

16. (a) Informant Charley McCray
(b) Address Catron, Mo.17. (a) Burial (b) Date thereof 3/30/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Catron Mo18. (a) Signature of funeral director [Signature] 531
(b) Address Lilbourn Mo19. (a) Mar 29/41 (b) E.E. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid 92
(c) City or town Catron, Mo RT 8
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 29 day 1941
year 1941 hour 12 30 P. M. minute _____ M.21. I hereby certify that I attended the deceased from
March 18 1941 to Mar 29 1941, 19____
that I last saw her alive on Mar 18 1941, 19____
and that death occurred on the date and hour stated above.Immediate cause of death Broncho Pneumonia 10 da
Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 E.E. Jones (M. D. or other) 11
Address Lilbourn Mo Date signed 3/29/41

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

107

RECEIVED

District Health Officer No.

District File Number 441-41

Date Filed 4/11/41

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 Not Embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 2627

P. O. Address Gilbourn 410

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11465-

Registration District No. 274

Primary Registration District No. 4063

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Sturgeon
(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 Rosie Lee Mc Cray
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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days 29 If less than one day _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (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 29
year _____ 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 Bronchopneumonia Duration today

Due to No complications

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) NO

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? _____

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

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

Address Lilbourn Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

11465