

No. 2
17-39
X23139

MAY 9 1941

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 124

Primary Registration District No. 3009

Registrar's No. 146

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days) 15 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1941 hour 3:50 minute 0 M.

21. I hereby certify that I attended the deceased from 7/27/41
_____, 19____, to 4/11/41, 19____;
that I last saw her alive on 4/11/41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Meningitis - Pneumonia
Lobar Pneumonia
Due to Whooping Cough

Due to _____
Other conditions
(Include pregnancy within 3 months of death) 9

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Chas. J. Herlihy (M. D. or other) _____
Address Cape Girardeau Mo. Date signed _____

3. (a) PRINT FULL NAME Rajana Kay Binford

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 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 12 12 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 29
hr. _____ min.

9. Birthplace Matthews 0 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Deward Binford

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

14. Maiden name Nettie May Binford

15. Birthplace Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Nettie May Binford

(b) Address Matthews, Mo.

17. (a) Burial (b) Date thereof 4 12 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carpenters Cemetery

18. (a) Signature of funeral director John A. ...

(b) Address Sikeston, Missouri

19. (a) 4-11-41 (b) Chas. J. Herlihy
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration
9 hours
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.