

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 604

Primary Registration District No. 5805

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural Le Sieur Mo.  
(c) Name of hospital or institution: Mo. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no.  
In this community About 35 years.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Rural Le Sieur  
(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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March, day 8  
year 1941 hour 8:45 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from on 3/8/41  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;

that I last saw her alive on 3/8/41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Uterine Hemorrhage (Labor)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 10.8  
(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? \_\_\_\_\_

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

23. Signature A. J. O'Reilly (M. D. or other) \_\_\_\_\_  
Address Portageville Mo. Date signed \_\_\_\_\_

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

3. (a) PRINT FULL NAME LORA LE SIEUR

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

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

6. (b) Name of husband or wife WENNIE LESIEUR 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased About 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
about 56 hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business No

MOTHER FATHER { 12. Name TOM SANDERS

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

14. Maiden name MARINA Mc Coy

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

16. (a) Informant VERGA KNIGHT

(b) Address PORTAGEVILLE, MO.

17. (a) BURIAL (b) Date thereof MARCH 9-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PORTAGEVILLE

18. (a) Signature of funeral director Richards and Co

(b) Address New Madrid Mo.  
19. (a) 4/16/41 (b) MD  
(Date received from registrar) (Registrar's signature)

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**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..... *No* .....

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, above space should be left blank.**