

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural
(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 ✓
In this community Five months (Specify whether years, months or days)

8. (a) PRINT FULL NAME Gloray Richmond

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

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

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

7. Birth date of deceased Missouri Missouri 1889
(Month) (Day) (Year)

8. AGE: Years 52 Months None Days None If less than one day ✓ hr. ✓ min.

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

10. Usual occupation House Keeping (at home)

11. Industry or business _____

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown USA
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown USA
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Richmond

(b) Address Billbourn Mo RFD 1 - Box 144

17. (a) Catholic Burial (b) Date thereof June 8 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ocealia Ark

18. (a) Signature of funeral director T. C. Knight

(b) Address Parma Mo

19. (a) 6-7-41 (b) D. H. Hollensted
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ark (b) County Miss 27
(c) City or town Rural 0
(If outside city or town limit - write "RURAL") 0
(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 June day 5th
year 1941 hour 7 minute — P. M.

21. I hereby certify that I attended the deceased from 5-27-41, 19____, to 6-5-41, 19____;
that I last saw him alive on 6-3-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Myocardial Degeneration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93 H

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? 52 lb

(Specify type of place) _____ (e) Means of injury _____

23. Signature D. H. Hollensted (M. D. or other) 200

Address Parma - Mo Date signed 6-6-41

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

RECEIVED

District Health Officer No. 2,

District File Number 741-898

Date Filed 7/15/41

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Thomas C Knight
Licensed Embalmer No. 2109
P. O. Address Perma 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.