

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Malden Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town "near" Malden (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

3. (a) PRINT FULL NAME Peggy Sue Perry

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 —

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

7. Birth date of deceased Feb. 23-41 (Month) (Day) (Year)

8. AGE: Years 0 Months 3 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Baby

11. Industry or business _____

12. Name N. P. Perry

13. Birthplace Ark. 1 (City, town, or county) (State or foreign country)

14. Maiden name Rula Mae Washell

15. Birthplace Ark 1 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature N. P. Perry

(b) Address Malden and Rural

17. (a) Burial (b) Date thereof June-23-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Cemetery

18. (a) Signature of funeral director Landers Funeral Home

(b) Address Campbell av.

19. (a) 6-22-41 (b) D. E. W. W. W. (Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22 year 1941 hour 10 minute 20A .M.

21. I hereby certify that I attended the deceased from on June 21, 1941, to _____, 19____; that I last saw her alive on June 21, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery B C

Duration 1 day

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 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? 534

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

23. Signature H. P. Davis (M. D. or other) 0

Address Malden Date signed 6/22/41

RECEIVED

District Health Officer No. 2,

District File Number 241-888

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.....

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.