

13-40
7-39
X23159

FILED AUG 13 1941

Primary Registration District No. **4553**

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

1. PLACE OF DEATH:

(a) County **Scott**

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

(c) Name of hospital or institution: **Sikeston General**
(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 **Robert Henry Cade**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M** () race **W**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **1 1 1916**
(Month) (Day) (Year)

8. AGE: Years **25** Months **6** Days **24**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **none**

11. Industry or business _____

MOTHER FATHER

12. Name **Moses Cade**

13. Birthplace **East Prairie Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Cumy Presson**

15. Birthplace **East Prairie Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Moses Cade**

(b) Address **Matthews Mo.**

17. (a) **Burial** (b) Date thereof **7/26/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Gideon Mo.**

18. (a) Signature of funeral director **H. H. Hittenton**

(b) Address **Sikeston MO**

19. (a) **8-4-41** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid** **72**

(c) City or town **Matthews**
(If outside city or town limits, write "RURAL") **0**

(d) Street No. _____
(If rural, give location) **0**

(e) If foreign born, how long in U. S. A.? **1** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **25**
year **1941** hour **9** minute **25** a.m.

21. I hereby certify that I attended the deceased from **7/24/41**
19____, to **7/25/41** 19____;

that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Basal skull fracture of base
traumatic amputation
Due to **fall from ladder**
stroke
Due to **hemorrhage**
Other conditions **old hemiplegia**
(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy **170C 1 21**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **7-24-41**

(c) Where did injury occur? **Highway 6 1/2 miles N of Matthews**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**
Public Highway
(Specify type of place)

While at work? **no** (c) Means of transport **hit by car**

23. Signature **H. M. [Signature]** (M. D. or other) **0**

Date signed **7/25/41**

RECEIVED

District Health Office No. 2

District File Number 841-104

Date Filed 8-11-41

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

Frank Embalmer

Registered Apprentice No. _____

working under my personal supervision.

Signed

Hunter Abritter

Licensed Embalmer No.

4210

P. O. Address

J. K. K. K.

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.