

FILED OCT 14 1941

Registration District No. 004

Primary Registration District No. 5178

State File No. ✓

Registrar's No. _____

1. PLACE OF DEATH

(a) County New Madrid
(b) City or town Cameron
(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 1 week (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Cameron (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME GEORGIA JOAN CHERRY

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

20. DATE OF DEATH: Month Sept day 22
year 1941 hour 3 minute 55A.M.

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced Infant
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from Sept 21 1941 to Sept 22 1941
that I last saw him/her alive on Sept 22 1941
and that death occurred on the date and hour stated above.

7. Birth date of deceased Sept 22 1941
(Month) (Day) (Year)

Immediate cause of death Enter cranial hemorrhage & Prematurity
Due to _____
Due to _____

8. AGE:	Years	Months	Days	If less than one day
				<u>2</u> hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Lawrence Cherry

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

14. Maiden name Mapine Lee

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

16. (a) Informant Lawrence Cherry

(b) Address Cameron Mo

17. (a) Buried (b) Date thereof 9-22-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director Edwards

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

Major findings: Of operations none

Of autopsy none

19. _____

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? _____

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

23. Signature R. C. Conrad, M.D. M.D. or other _____

Address 114 W. 7th Date signed 9-22-41

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

22
000

RECEIVED

District Health Office No. 2,

District File Number 1041-1329

Date Filed 10/2/41

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.....

Not Embalmed....., 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 32088

Registration District No. 604

Primary Registration District No. 5798

Registrar's No.

1. PLACE OF DEATH: New Madrid

(a) County.....

(b) City or town.....
(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.....
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Georgia J. Cherry

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22 year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

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

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

7. Birth date of deceased Sept 22 1904
(Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) min.

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

Major findings:
Of operations.....

Of autopsy.....

16. (a) Informant.....
(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 11-10-41 (b) Wm O'Bannon
(Date received local registrar) (Registrar's signature)

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..... (M. D. or other).....
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

32088