

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 15 1941
604

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32120

Registration District No. 604

Primary Registration District No. 5-802

Registrar's No.

1. PLACE OF DEATH:

- (a) County New Madrid
(b) City or town New Madrid 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 _____ (Specify whether)

In this community _____ years, months or days

8. (a) PRINT FULL NAME Thomas Richardson Alexander

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, married

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

7. Birth date of deceased Dec 14 1917 (Month) (Day) (Year)

8. AGE: Years 23 Months 9 Days 14 If less than one day hr. _____ min.

9. Birthplace Pin Point, Ala. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Cotton buyer

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas
13. Birthplace Union City (City, town, or county) Tenn. 1 (State or foreign country)
14. Maiden name Minnie Mae Siddons
15. Birthplace Union City (City, town, or county) Tenn. 1 (State or foreign country)

16. (a) Informant Thomas Alexander

(b) Address Portageville, Mo

17. (a) Rural (b) Date thereof 9 29 1941 (Month) (Day) (Year)

(c) Place: burial or cremation New Madrid Cem.

18. (a) Signature of funeral director L. Richards Jr.

(b) Address New Madrid

19. (a) 10/15/41 (b) Wm O'Sannum (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County New Madrid
(c) City or town Portageville, Mo 072 (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 Sept day 28 year 1941 hour 3 minute 0 M.

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

Immediate cause of death Severe skull fracture, cuts on face, broken ribs, loss of blood.

Due to car wreck, collided with another car.

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) accident 072

(b) Date of occurrence Sept 28-1941 3 P.M.

(c) Where did injury occur? 3 miles south New Madrid Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? high way 61

While at work? no (Specify type of place) (e) Means of injury

23. Signature L. Richards Jr. (Dr. or other) Coroner

Address New Madrid Date signed 9-28-41

RECEIVED

District Health Office No. 2, OK
-2-8-
SEX 10

District File Number 1041-1404

Date Filed 10/8/41

RECORDED

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32120
Registrar's No. _____

Registration District No. 604 Primary Registration District No. 5802

1. PLACE OF DEATH:

- (a) County New Madrid
(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)

3. (a) PRINT
FULL NAME

Thomas R. Alexander

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m
7. (b) Name of husband or wife Lucille Alexander 7. (c) Age of husband or wife if alive 21 years
8. Birth date of deceased Dec 14, 1917 (Month) (Day) (Year)

8. AGE: Years 23 Months 9 Days 10 (If less than one day, in min.)

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)

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

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

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) 10-3-41 (b) Wm O'Sannon
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

- 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 sta-
tistically.

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? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

- Address _____ Date signed _____

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

SUPPLEMENTARY

32/20