

2
11
39
26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 8 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32728 ✓

Kendig 821

Registration District No. _____

Primary Registration District No. 4553 ✓

State File No. _____

Registrar's No. _____

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 1 week
(Specify whether
In this community 25 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 230 Daniel
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Oscar Earl Lathom

3. (b) If veteran, name war _____ 3. (c) Social Security No. 497-01-1824

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary L Lathom 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased 6 25 1885
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 17 If less than one day
hr. _____ min. _____

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

10. Usual occupation Printer

11. Industry or business _____

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

16. (a) Informant Mrs. O. E. Lathom

(b) Address Sikeston Mo.

17. (a) Burial (b) Date thereof 9/14/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director Samuel Alkhitia

(b) Address Sikeston Mo.

19. (a) 10-1-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 12
year 1941 hour 4 minute 30 a. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on 9-12-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death:
Stroke of the Brain, Paralytic illness,

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) Accident

(b) Date of occurrence Sept 5-41

(c) Where did injury occur? Well on road
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Highway
(Specify type of place) (e) Means of injury fall

23. Signature Howard M. [Signature] M. D. or other _____

Address Sikeston Mo. Date signed 9/13/41

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

RECEIVED

District Health Office No. 2,

District File Number 1041-1266

Date Filed 10/6/41

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. ~~2241~~

working under my personal supervision.

Signed.....

Hunter Albright

Licensed Embalmer No. ~~4210~~ 4210

P. O. Address..... Sikeston 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, fact should be so stated above.

PHONES:

Office 610

Residence 761

DR. H. M. KENDIG

Physician and Surgeon

SIKESTON, MO.

Reg. No. 4412

HOURS:

9-12 A. M.

2-5 and

R

State Board of Health
Patient's Name
Jefferson City Mo

Dear Sir:

This was not Homicide
but an accident - if
Homicide was written
on Death Certificate it is
~~a mistake~~ an error

TAKE THIS TO

BOWMAN'S DRUG STORE

SIKESTON, MISSOURI

Date: 1/2/24

Never offer this Prescription to a friend for a seemingly similar ailment. It is personal prescription, prepared for your specific illness at this particular time

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32 728
Registrar's No. _____

Registration District No. 821 Primary Registration District No. 4553

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:
(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 Oscar E. Latham

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

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

7. Birth date of deceased 6-25-1862
(Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 9 day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

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) Homicide

(b) Date of occurrence Sept 5-41

(c) Where did injury occur? Bill on curb (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway

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

23. Signature Howard M. King (M.D. or other)

Address Sikeston, Mo. Date signed _____

SUPPLEMENTARY

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