

JAN 14 1942  
Registration District No. 605

Primary Registration District No. 4359

Registrar's No. 5804

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

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: 1

(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 Mo. (b) County New Madrid

(c) City or town Catron  
(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 Joy Nolas ROE.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27  
year 1941 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from 1 day  
1940 Dec 27 1941  
that I last saw her alive on Dec 23 1941  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color of race W.

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

6. (b) Name of husband or wife RC 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased: Oct 18 1880  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>61</u>	<u>1</u>	<u>9</u>	_____ hr. _____ min.

Immediate cause of death: Cancer of the uterus Duration 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Mrs Nolas G

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

14. Maiden name Sarah Westy

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

Other conditions Diabetes mellitus 6 mos

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Chyde Roe

(b) Address Catron Mo

17. (a) Burial (b) Date thereof 12-29-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walberry Cemetery near Easton Ark

18. (a) Signature of funeral director E. E. Jones

(b) Address Malden Mo

19. (a) E. E. Jones (b) E. B. Rademaker  
(Deputy 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? \_\_\_\_\_

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

23. Signature E. E. Jones (M. D. or other) D

Address Patton Mo Date signed 12-27-41

**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..... *V. H. Craig* .....

Licensed Embalmer No..... *2850* .....

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, fact should be so stated above.**