

Dr Sarno
Registration District No. 603

Primary Registration District No. 4357

State File No. _____
Registrar's No. _____

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Morehouse 7 AM
(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 9 Years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Morehouse
(If outside city or town limits, write "RURAL")
(d) Street No. no street Number (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Chalen Charles Marcus

3. (b) If veteran, name war X 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 Gladys Marcus 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased 7 11 1907 (Month) (Day) (Year)

8. AGE: Years 34 Months 5 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Lumber Mill

12. Name Franklin Marcus

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

14. Maiden name Ella Harmon

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

16. (a) Informant Gladys Marcus

(b) Address Morehouse Missouri

17. (a) Burial (b) Date thereof 12/30/41 (Month) (Day) (Year)

(c) Place: burial or cremation Charleston Mo

18. (a) Signature of funeral director Hunter Albright

(b) Address Sikeston Mo.

19. (a) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 28 year 1941 hour 12 minute 20 a.m.

21. I hereby certify that I attended the deceased from 12-21 1941 to 12-28 1941
that I last saw him alive on 12-28 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Ludwig Angina
Step 2 operation

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 15A

Of autopsy _____

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 Dr Sarno (M. D. or other) _____

Address Morehouse Mo. Date signed 12-28-41

Duration 1 week
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

V. S. 1941
SGP

RECEIVED

District Health Office No. 2,

District File Number 142-173

Date Filed 1-23-42

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

Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed Hunter Albritton

Licensed Embalmer No. 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.

Registration District No. **603**

Primary Registration District No. **4857**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **more house**
(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

Chalen C. Marcus

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 **July 11 1908**
(Month) (Day) (Year)

8. AGE: Years **34** Months **5** Days **14** If less than one day _____ min.

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

10. Usual occupation

11. Industry of 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) **May 25/42** (b) **Mae Brown**
(Date received by 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 **December** 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 _____

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) _____
(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 _____

