

FILED MAR 25 1942

Registration District No. 221

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston, Mo.
(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 Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Scott
(c) City or town Sikeston, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 7 mi N.E.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mattie Jones

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

4. Sex F 5. Color or race Col 6. (a) Single, widowed, married divorced
6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 2 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Bill Jones

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

14. Maiden name Bertha Jones
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Bill Jones

(b) Address Sikeston, Mo.

17. (a) Funeral (b) Date thereof July 8, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation M. Mullin, Mo.

18. (a) Signature of funeral director Allen Elee

(b) Address Sikeston, Mo.

19. (a) 2-7-42 (b) NO Thompson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 17
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 7 - 1940
and that death occurred on the date and hour stated above.
I last saw her alive on July 17, 1940

Immediate cause of death Bronchopneumonia Duration 1 day

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy None

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 1

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

Address Sikeston Date signed 7-4

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-38 I 13531

RECEIVED

District Health Office No. 2;

District File Number 3427372

Date Filed 3/12/42

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.....

....., 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

Registration District No. 821

Primary Registration District No. 4553

1. PLACE OF DEATH:

(a) County South
(b) City or town Sturgeon
(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 years, months or days)
In this community _____

3. (a) PRINT FULL NAME Mattie Jones

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

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

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

7. Birth date of deceased June 2
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 July Day _____
Year 1940 Hour _____ Minute _____ M.

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

Broncho Pneumonia

Due to _____

Due to N.M.O

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)
f. 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

SUPPLEMENTARY

S-7993