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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 10 1942

Registration District No. 274

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4063

State File No. _____

Registrar's No. _____

11451

1. PLACE OF DEATH:

(a) County. New Madrid
(b) City or town. Lilbourn, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community BETTIE TONEY about 20 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County New Madrid
(c) City or town. Lilbourn, 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 Feb day 5
year 1942 hour 7:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw her alive on Jan 28 - 1942
and that death occurred on the date and hour stated above.

Immediate cause of death. The Abdomen
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury. 1

23. Signature GN Helmer (M. D. or other)
Address Lilbourn Date signed 2-7-42

3. (a) PRINT FULL NAME BETTIE TONEY

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

4. Sex. 3 FEMALE 5. Color or race. C 6. (a) Single, widowed, married, divorced. MARRIED

6. (b) Name of husband or wife. ELNOR TONEY 6. (c) Age of husband or wife if alive. 72 years

7. Birth date of deceased. About 1867
(Month) (Day) (Year)

8. AGE: Years About 75 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace. UNK Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation. HOUSEWIFE

11. Industry or business. ✓

12. Name MANUEL MORGAN

13. Birthplace. UNK 4
(City, town, or county) (State or foreign country)

14. Maiden name UNK

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

16. (a) Informant. ELNOR TONEY

(b) Address. LILBOURN, MO

17. (a) BURIAL (b) Date thereof. 2-8-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Community

18. (a) Signature of funeral director. Richards unleso

(b) Address. New Madrid, Mo.

19. (a) 4-2-42 (b) Mr. J. S. Parrett
(Date received local registrar) (Registrar's signature) 1271

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

22
0

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 Leo Hedgicott
Licensed Embalmer No. 3803
P. O. Address New Madrid

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. 1143-1

Registration District No. 274

Primary Registration District No. 4063

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Lillebourne
(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)

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 _____

3. (a) PRINT FULL NAME Bella Toney

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

4. Sex F 5. Color or race _____ 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 _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day, _____ min.)
About 75

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 3 Year 1948 hour 7 minute 0 P. M.

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

Due to suicide
state

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? _____

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

23. Signature Dr. Helen (Physician's name)
Address Lillebourne Date signed 2-2-48

SUPPLEMENTARY

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

11457