

FILED MAY 1 1942

State File No. _____
Registrar's No. 29

Registration District No. 5-6-7 851 Primary Registration District No. 5-7-6-7 5768

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

1. PLACE OF DEATH:

(a) County Miss

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

(c) Name of hospital or institution: James Beason Tub
(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 County Miss

(c) City or town near Doena, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 15 miles East of E. Prairie
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME MAUDIE LOU GAMMONS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 1942 hour _____ minute _____ M.

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

3. (c) Social Security No. none

21. I hereby certify that I attended the deceased from _____
No Doctor, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased March 25, 1942
(Month) (Day) (Year)

Immediate cause of death Blue baby Duration _____

8. AGE:	Years	Months	Days	If less than one day
			<u>12</u>	hr. _____ min. _____

Due to Mitral Insufficiency

9. Birthplace Fulton Co Ky
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation repair

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

11. Industry or business _____

12. Name Miss Jewel Gammons

13. Birthplace Fulton Co Ky
(City, town, or county) (State or foreign country)

14. Maiden name Maude Addams

15. Birthplace Fulton Co Ky
(City, town, or county) (State or foreign country)

Major findings: 157e PHYSICIAN _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Miss Jewel Gammons

(b) Address East Fulton Co Ky

17. (a) Burial (b) Date thereof 3-7-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W O W

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? _____

18. (a) Signature of funeral director W O W Shelby

(b) Address East Prairie, Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature) 572

While at work _____ (Specify type of place)

(a) Means of injury _____

23. Signature W O W Shelby (M. D. or other) Coroner

Address East Prairie, Mo Date signed 5/6/42

Handwritten scribbles and illegible text at the top left.

Handwritten scribbles and illegible text at the top right.

Handwritten scribbles.

MANDIE TON DAMMONS

5481

Handwritten scribbles.

Handwritten scribbles.

Handwritten scribbles.

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

Travis Shelby
not embalmed

Licensed Embalmer No.

P. O. Address

2726 East Grand, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14966
Registrar's No. _____

Registration District No. 1031

Primary Registration District No. 5768

1. PLACE OF DEATH:

(a) County Miss. Dorena
(b) City or town Dorena
(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 Mo (b) County Miss
(c) City or town Dorena
(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 Maudie L. Gammons

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

4. Sex F 5. Color or race w 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 mch-25-1942
(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 _____

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-9-42 (Date received local registrar) (b) Fannie L. Bigman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day _____ year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I have seen him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death Blue baby

critical symptoms

Due to _____

Due to 15-7-2

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

Major findings: Of operations _____ Of autopsy _____

Duration

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

