

FILED MAY 26 1942 603

Registration District No. ....

Primary Registration District No. 4357

Registrar's No. ....

1. PLACE OF DEATH:

(a) County: New Madrid

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

(c) Name of hospital or institution: None  
(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: \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Shala Rose Kindred

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife: Oscar C. Kindred 6. (c) Age of husband or wife if alive: 19 years

7. Birth date of deceased: 10 -- 27 -- 42  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>2</u>	<u>24</u>	_____ hr. _____ min.

9. Birthplace: Morehouse Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

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

MOTHER FATHER { 12. Name: Oscar C. Kindred

13. Birthplace: Parma Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name: Imogene Shoulders

15. Birthplace: Morehouse Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant: mother

(b) Address: Morehouse

17. (a) Burial (b) Date thereof: 12-18-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park

18. (a) Signature of funeral director: Curly Taylor

(b) Address: Sikeston Mo.

19. (a) May 25 42 (b) Mac Brown  
(Date received local registrar) (Registrar's signature)

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. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month I -- day 17  
year 1942 hour \_\_\_\_\_ minute 40 M.

21. I hereby certify that I attended the deceased from Jan 16 1942 to Jan 17 1942  
that I last saw her alive on Jan 16 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia

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

Due to \_\_\_\_\_ 108

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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: 9

23. Signature: \_\_\_\_\_ (M. D. or other)

Address: \_\_\_\_\_ Date signed: \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

72  
3  
0

12  
3  
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.....

*Was not embalmed.*

....., 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, fact should be so stated above.**