

S. No. 1-1
5-1-1
X26390

FILED NOV 14 1942 3
Registration District No. **3074**

Primary Registration District No. **3074**

Registrar's No.

100
5
2
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Scott**

(b) City or town **Sikeston**
(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 **2 years**
(Specify whether years, months or days)

In this community **2 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott**

(c) City or town **Sikeston**
(If outside city or town limits, write "RURAL")

(d) Street No. **Gladys St.**
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME **Rosie Waters**

3. (b) If veteran, name war **X**

3. (c) Social Security No. **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **30**
year **1942** hour **10** minute **a.m.**

21. I hereby certify that I attended the deceased from **9-10-42**
9-29-42, 19... to... 19...
that I last saw **her** alive on **9-25-42**, 19...
and that death occurred on the date and hour stated above.

4. Sex **F** Color or race **C**

6. (a) Single, widowed, married, divorced **W 9**

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

7. Birth date of deceased **Sept 2 1888**
(Month) (Day) (Year)

Immediate cause of death... **Labor Pneumonia** **2 Weeks**

Due to...

Due to...

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

8. AGE: Years **59** Months **0** Days **28**
If less than one day hr. min.

9. Birthplace **Vicksburg Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cotton Picker**

11. Industry or business

12. Name **Unknown**

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

14. Maiden name **"**

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Lum Robinson**

(b) Address **Sikeston Mo.**

17. (a) **Burial** (b) Date thereof **10/1/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **McMullin Mo.**

18. (a) Signature of funeral director **H.W. Albritton**

(b) Address **Sikeston Mo.**

19. (a) **10-26-42** (b) **Lewis Largent**
(Date received local registrar) (Registrar's signature)

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) Means of injury

23. Signature **Lewis Largent** (M. D. or other)

Address **Sikeston** Date signed **10-17-42**

RECEIVED

District Health Office No. 2

District File Number 1142-1451

Date Filed 11-12-42

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sebastian
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Rosie Water

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race c

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____

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

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

8. AGE: Years 5 Months 0 Days 18
If less than one day in min.

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

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 Jan Day 13 Year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ die on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

35004