Dr Bond

15072

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 10 1943

Registration District No. 067 — Primary Registration District No. 5901 — Registrar's No. 25

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

1. PLACE OF DEATH:

(a) County: Pemiscot

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

(c) Name of hospital or institution: Cooperville Twp
(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: 48 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Pemiscot

(c) City or town: Hayti Rural
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No): 0

If yes, name country:

3. (a) PRINT FULL NAME: Virgie Patrick

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

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Tracy Patrick

6. (c) Age of husband or wife if alive: 48 years

7. Birth date of deceased: November (Month) 7 (Day) 1895 (Year)

8. AGE: Years 47 Months 5 Days 26 If less than one day hr. min.

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

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Charlie Abart
13. Birthplace: Indiana (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Bell Spines
15. Birthplace: Indiana (City, town, or county) (State or foreign country)

16. (a) Informant: Tracy Patrick
(b) Address: Hayti Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-3-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Dry Bayou Cemetery

18. (a) Signature of funeral director: Herman Undt Co
(b) Address: Steele Missouri Box 121

19. (a) May 4-43 (Date received local registrar) (b) George R. Blackwell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3 year 1943 hour 3:00 minute A.M.

21. I hereby certify that I attended the deceased from ~~Dec~~ April 17, 1943, to May 1, 1943; that I last saw h~~im~~er alive on May 2, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of liver, gall bladder and ectodermal

Due to: Tuberculosis lung.

Due to:

Other conditions: Chronic Nephritis
(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: J. Bond M.D. (M. D. or other)

Address: Hayti, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

13.71

4-43-200

MAY 18 1943

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.....

Body 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.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15072

Registration District No. 267 Primary Registration District No. 5901 Registrar's No. 35

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Rural
(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 Virgie Patrick

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

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 47 Months 5 Days 26 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3

year 1943 hour minute M.

21. I hereby certify that I attended the deceased from

, 19 to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of liver

Due to Gall bladder & extending to rt lung

Due to Primary seat of malignancy was the "liver"

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 46f

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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-15072