No. 2
5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

19227

State File No.

FILED JUN 7 1943

Registration District No. 552

Primary Registration District No. 6114

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott County

(b) City or town Morley Mo (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 6 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County SCOTT 100 0

(c) City or town MORLEY 0 (If outside city or town limits, write "RURAL")

(d) Street No. 1 MILE off 61 — BASE LINE RD. (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME SARAH NAVE

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE

5. Color or race COL 3

6. (a) ~~Single, widowed~~, married, ~~divorced~~ MARRIED 1

6. (b) Name of husband or wife SAM NAVE

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Jan (Month) 21 (Day) 1895 (Year)

8. AGE: Years 48 Months 3 Days 16 If less than one day hr. min.

9. Birthplace KEMPER COUNTY (City, town, or county) MISS. / (State or foreign country)

10. Usual occupation HOUSEWIFE

11. ~~Industry or business~~ ~~GEO. LOCKETT~~

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

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

16. (a) Informant SAM NAVE

(b) Address SCOTT COUNTY, MORLEY MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 9 1943 (Month) (Day) (Year)

(c) Place: burial or cremation MORLEY MO

18. (a) Signature of funeral director F. J. SPARKS

(b) Address CAPE GIRARDEAU, MO

19. (a) May-9-43 (Date received local registrar) (b) Mrs. Wm Foster (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 7 year 1943 hour 2:45 minute P.M. M.

21. I hereby certify that I attended the deceased from 5-4- 1943, 19, to 5-7, 1943 that I last saw her alive on 5-5- 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no

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 May field (M. D. or other)

Address Vanderbilt Mo Date signed 5-8-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 643-742
Date Filed 6-3-43

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 Frank Sparks

Licensed Embalmer No. 3855

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 332 Primary Registration District No. (6114) Registrar's No. .....

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

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: (Morley (rural) Twp.)
(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: 6 yrs.

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: Sarah Navel

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

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

4. Sex: F

5. Color or race: B

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: Jan (Month) 21 (Day) 1895 (Year)

8. AGE: Years 48 Months 3 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace: Mis (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) ..... (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) (Mrs. W. Foster) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day ..... year 1963 hour ..... minute ..... M.

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

Immediate cause of death	Duration
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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

S-19227