No. 2
9-4-41
17-39
X29484

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. 25580

FILED JUL 21 1943

Registration District No. 42

Primary Registration District No. 5830

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town West Town
(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 7 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid 72

(c) City or town Rural 0
(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 0

3. (a) PRINT FULL NAME Mabel C. Finney

3. (b) If veteran, name war X

3. (c) Social Security No. X

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 7 (Month) 13 (Day) 1891 (Year)

8. AGE: Years 51 Months 11 Days 25 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name J.D. Hogan
13. Birthplace Sumter (City, town, or county) So. Carolina (State or foreign country)

MOTHER
14. Maiden name Cinthia Cloud
15. Birthplace Sumter (City, town, or county) So. Carolina (State or foreign country)

16. (a) Informant V.E. Hammock
(b) Address Canalou Mo. Box 93

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/43 (Month) (Day) (Year)
(c) Place: burial or cremation Atkins Ark.

18. (a) Signature of funeral director H.W. Albritton
(b) Address Sikeston Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 8
year 1943 hour 10; minute 05 a M.

21. I hereby certify that I attended the deceased from March 10, 1943, to July 9, 1943;
that I last saw her alive on July 9, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Metastasis - Carcinoma

Due to Ca of Breast

Due to 50

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration 1 year

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 D

23. Signature J.M. Sarno M.D. (M. D. or other)
Address Morehouse, Mo. Date signed 7/13/43

538
1/43

1052

(Licensed Embalmer's Statement on Reverse Side)

JUL 21 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Fenton Albert

Licensed Embalmer No. 4210

P. O. Address Silverton

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.

No. 2B
—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

AUG 1943

State File No.

Registration District No. 242 Primary Registration District No. 5830 Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Crocker West 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

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 Mabel C. Finney

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 July 19 1893
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) ark. (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) Aug 22 1943 (Date received local registrar) (b) Mae Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 8 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.

	Duration
Immediate cause of death	
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

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

S-25580