No. 2
—2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 18 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29502

Registration District No. 332

Primary Registration District No. 6114 6113

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town ~~Morley~~ Moreland Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route 1
(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 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

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

(d) Street No. Route 1
(If rural, give location)

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

If yes, name country ----------

3. (a) PRINT FULL NAME Sam Nave

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

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

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Sarah L. Nave

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

7. Birth date of deceased January 20, 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
51	6	9	hr. min.

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

10. Usual occupation Farmer

11. Industry or business -------

FATHER
12. Name Jack Nave
13. Birthplace Scooba, Miss. (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Cynthia Spencer
15. Birthplace Scooba, Miss. (City, town, or county) / (State or foreign country)

16. (a) Informant Sam Nave, Jr.
(b) Address Route 1, Morley, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation McMullen, Mo.

18. (a) Signature of funeral director F. S. Sparks
(b) Address Cape Girardeau, Mo.

19. (a) Aug 2-43 (Date received local registrar) (b) Mrs. Wm Foster (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1943 hour 3 minute 40 P.M.

21. I hereby certify that I attended the deceased from July 23, 1943 to July 28, 1943
that I last saw him alive on July 28, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis c Uremia — Duration 6 mos

Due to

Due to

Other conditions 131 b
(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 J. M. Sarno (M. D. or other) M.D.
Address Marchause Mo Date signed 8/2/43

112 X (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 843-104
Date Filed 8-13-43

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. 8455

P. O. Address Cape Girardeau 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.

No. 2B
5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31 1943

Registration District No. (331) Primary Registration District No. (113) Registrar's No. 10

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Miss[illegible] 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

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 Tepa Anna Scott

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 May 7 1870 (Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Penn (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 July Day 14 year 1943 hour P.M. 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 — 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

29502