

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

21159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38769

FILED DEC 8 1943  
Registration District No. 209

Primary Registration District No. 5825

State File No. \_\_\_\_\_  
Registrar's No. 4356

1. PLACE OF DEATH:  
(a) County: New Madrid  
(b) City or town: Malden Road  
(c) Name of hospital or institution: Corona Hosp  
(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)

3. (a) PRINT FULL NAME: Earl Gene Treat  
3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: male 5. Color or race: white 6. (a) Single, widowed, married, divorced, infant: divorced infant  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Nov 3 43  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: Malden Road I 0  
(City, town, or county) (State or foreign country)

10. Usual occupation: infant

11. Industry or business: \_\_\_\_\_  
MOTHER FATHER { 12. Name: Riley Treat  
13. Birthplace: Leolis Ark  
(City, town, or county) (State or foreign country)  
14. Maiden name: Lucille Kumbler  
15. Birthplace: Marshall Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant: Riley Treat  
(b) Address: Malden Rd 1  
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) Nov. 30-43 (b) Mrs S. B. Radwin  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: New Madrid  
(c) City or town: Malden Rd I  
(If outside city or town limits, write "RURAL")  
(d) Street No.: Road I  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.: Coming West of Canada

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8  
year 1943 hour 10 minute 20 AM.  
21. I hereby certify that I attended the deceased from Nov 3  
\_\_\_\_\_, 1943, to Nov. 8, 1943  
that I last saw him alive on Nov 8, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Malformation of Digestive organs  
Duration: 157 min  
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?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury: 5  
23. Signature: Dr. C. A. Tolson (M. D. or other)  
Address: Malden Date signed: Nov 8 1943

RECEIVED

District Health Office No. 2,

District File Number 1243-151

Date Filed 12-6-43

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**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.....

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.**

Registration District No. 239 Primary Registration District No. 5-825

**1. PLACE OF DEATH:**  
(a) County New Madrid  
(b) City or town Camo Camp Route 1  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Earl Gene Treat  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 Nov. 3  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

12. Name Riley M. Treat

13. Birthplace Leslie Ark.  
(City, town, or county) (State or foreign country)

14. Maiden name Bessie J. Rumbell

15. Birthplace Marshall Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Riley M. Treat  
(b) Address Madison Mo. R 1

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4 3  
(Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Gilead

18. (a) Signature of funeral director None  
(b) Address \_\_\_\_\_

19. (a) Mar 30 1943 Mrs S Bladenaker  
(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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1943 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ alive 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 \_\_\_\_\_

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**

MOTHER FATHER

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

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