

No. 2
-9.4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39309**

FILED *[Signature]*
Registration District No. **333**

Primary Registration District No. **2074**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Sikeston General Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 11 days
(Specify whether)

In this community all of life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

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

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

(e) Citizen of foreign country? (Yes or No)
If yes, name country USA

3. (a) PRINT FULL NAME Lina Christone Pierce

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 20
year 1943 hour 1 minute 00 P.M.

21. I hereby certify that I attended the deceased from 11-8
1943 to 11-18 1943
that I last saw her alive on 11-18 1943
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Chasley 6. (c) Age of husband or wife if alive 62 years
23 (Month) 23 (Day) 1894 (Year)

7. Birth date of deceased

Immediate cause of death Carcinoma of the sigmoid colon

Due to _____

Due to Neuromeningitis (multiple) from bowel 1 mo.
Secondary carcinoma

Other conditions Secondary carcinoma
(Include pregnancy within 3 months of death)

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

44 9 27 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Wm. Gregory

{ 13. Birthplace Ky
(City, town or county) (State or foreign country)

{ 14. Maiden name Lula Lyle

{ 15. Birthplace Ky
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Major findings: _____

Of operations H&E

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. J. W. Jones

(b) Address Sikeston RFD #1

17. (a) Burial (b) Date thereof 11-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston

18. (a) Signature of funeral director H. Walbrinton

(b) Address Sikeston Mo

19. (a) 12/4/43 (b) Louie Legend
(Date received local registrar) (Registrar's signature)

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. E. McLean (M. D. or other) _____

Address Sikeston Mo Date signed 11-22-43

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

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 1243-1523

Date Filed 12-6-43

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

Embalmed

Registered Apprentice No. _____

working under my personal supervision.

Signed.

Hunter Alhitta

Licensed Embalmer No. 4210

P. O. Address Sakata

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.