

No. 2  
11-10-39  
-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3846

FILED FEB 11 1944

Primary Registration District No. 1708

Registrar's No.

1. PLACE OF DEATH: Peniscot

(a) County: Peniscot

(b) City or town: Rural Wardell  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Little River Inn  
(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: Mo (b) County: Peniscot

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME: Rose BANKS

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: 2

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: 7 (Month) 15 (Day) 1891 (Year)

8. AGE: Years 32 Months 9 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Miss (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation: House Work

11. Industry or business \_\_\_\_\_

12. Name: Will M. Brooks

18. Birthplace: North Galena (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name: Robt How

15. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant: Creola Bonwell

(b) Address: Warshersville 4110

17. (a) Buried (b) Date thereof: Jan. 16 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Wardell Cemetery

18. (a) Signature of funeral director: L. H. Hill

(b) Address: Zelma 4110

19. (a) 1-16-44 (b) J. J. Conway  
(Interreceived local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13  
year 1944 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from Jan. 12, 44 only, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw her alive on Jan. 12, 44, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho-pneumonia

Due to: Influenza

Other conditions: None  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature: A. A. Reeder (M. D. or other) \_\_\_\_\_  
Address: Portageville, Mo. Date signed: 1-16-44

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

MOTHER FATHER

390

(Licensed Embalmer's Statement on Reverse Side)

1-2-44

JAN 29 1952

OK  
Hedges

**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 Len Hill

Licensed Embalmer No. 2627

P. O. Address Gilbourn 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, above space should be left blank.**

Registration District No. 268

Primary Registration District No. 5906

1. PLACE OF DEATH:

(a) County: Pemiscot  
(b) City or town: Rural Little River Imp.  
(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: Rose Banks

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: F 5. Color or race: Colored 6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: July 15 1909  
(Month) (Day) (Year)

8. AGE: Years 52 Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace: Missouri  
(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: J. M. Hill

(b) Address: Lebanon

19. (a) 1-16-1944 (b) J. E. Greary  
(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 January 3  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
that I last saw him/her 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?

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

3846