

FILED FEB 7 1943

Registration District No. 243

Primary Registration District No. 6154

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural Sikeston Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Rockland Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 1 years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard
(c) City or town Rural Rockland Hosp
(If outside city or town limits, write "RURAL")
(d) Street No. Sumner, Mo. Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1943 hour 3 PM minute _____ M.

21. I hereby certify that I attended the deceased from Oct 30 1943 to Oct 31 1943
that I last saw him alive on Oct 30 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Colitis Duration _____

Due to _____

Due to 1190

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) _____ Means of injury _____

23. Signature E. J. Hester (M. D. or other) _____

Address Sikeston Mo Date signed 11-1-43

3. (a) PRINT FULL NAME Mary Ann Maqueen

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

4. Sex female 5. Color or race Colored

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased May 2 1942
(Month) (Day) (Year)

8. AGE: Years 1 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation child

11. Industry or business _____

12. Name Ardree Maqueen

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

14. Maiden name Jettie B.

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Mc Mullen

18. (a) Signature of funeral director Mattie Smith

(b) Address 1381 Mandeville St. Sikeston Mo

19. (a) 1-28-44 (b) None
(Data received local registrar) (Registrar's signature)

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

RECEIVED

District Health Office No. 2,

District File Number 147-138

Date Filed 1-13-44

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.