

No. 2
-5-42
5-17-39
X32873

State File No. _____

Registration District No. 107

Primary Registration District No. 3019

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Dunklin

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

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

(d) Length of stay: In hospital or institution _____ X
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin ¹³⁵

(c) City or town Halcomb
(If outside city or town limits, write "RURAL") ⁸

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ ⁰

3. (a) PRINT FULL NAME Jennie Hyde

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 3
year 1944 hour 1 minutes 2:30 P.M.

4. Sex Female 5. Color or race W 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 April 5 1959
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-21, 1943, to 2-3, 1944
that I last saw h. e. r. alive on 2-3, 1944
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>9</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death Nephritis (Chronic) ^{Duration to death 10 days}
Uremia
Senility

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

10. Usual occupation Housework

Due to _____

Due to _____

Other conditions fracture of right hip
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

Major findings:
Of operations _____

Of autopsy _____

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

16. (a) Informant Mrs. Opal Pope
(b) Address Halcomb, Missouri

17. (a) Burial (b) Date thereof 2-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield Cemetery

18. (a) Signature of funeral director Landes Funeral Home
(b) Address Camphers, Missouri

19. 2-12-44 (b) Julia Blaukush
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following: 135

(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. B. Presnell (M. D. or other) M.D.
Address Kennett, Mo. Date signed 2-11-44

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

RECEIVED

District Health Office No. 2,

District File Number. 344-404

Date Filed 3-3-44

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 Christina M Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 107

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Keenett
(c) Name of hospital or institution: Freemont Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12-21-43 to 2-3-44 (Specify whether years, months or days)

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

Jennie Hyde

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 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 nephritis (Chronic) (Duration)

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

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

7. Birth date of deceased April 5 (Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days _____ (Less than one day) min. _____

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

Due to Senility

Due to _____

Other conditions fracture of right hip (Include pregnancy within 3 months of death)
ADDITIONAL PHYSICIAN
Major findings: SUPPLEMENTARY INFORMATION REQUESTED
Of operations: _____
Of autopsy: _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 12-20-43
(c) Where did injury occur? Home, Dunklin, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? No (Specify type of place)
on floor (e) Means of injury slipped
23. Signature Dr. H. Keenell (M. D. or other) M.D.
Address Keenett, Mo. Date signed _____

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

SUPPLEMENTARY INFORMATION REQUESTED

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7075