

FILED APR 18 1944 293

Primary Registration District No. 4436

Registrar's No. 77

1. PLACE OF DEATH:

(a) County Palls
(b) City or town New London
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

Sussie Monroe

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

4. Sex Female 5. Color negro 6. (a) Single, widowed, married, divorced 1

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

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

8. AGE: Years about 77 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation house

11. Industry or business _____

12. Name Herry Payton

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

14. Maiden name Sussie Payton

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

16. (a) Informant Geneva Sparks

(b) Address New London Mo

17. (a) _____ (b) Date thereof 2 9 44 (Month) (Day) (Year)

(c) Place: burial or cremation New London Mo

18. (a) Signature of funeral director Geo E Roberts

(b) Address Hannibal Mo

19. (a) 2-9-44 (b) RL Berkley (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Palls
(c) City or town New London (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 2 day 5 year 44 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from many months, 19____, to _____, 19____, that I last saw her alive on Jan, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death coma Duration _____

Due to Sensitivity - Heart disease

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 H. P. Waters (M, D or other) _____
Address New London Mo Date signed 2/11/44

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

MOTHER FATHER

1171

RECEIVED

District Health Officer No. 10

District File Number 4-44-839

Date Filed APR 18 1944

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

Gus E Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal 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. May
Registrar's No. 770

Registration District No. 293 Primary Registration District No. 4426

1. PLACE OF DEATH
(a) County Ralls
(b) City or town New London
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Lussie Mansel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____ If less than one day _____ min.

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

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Data received local registrar)

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 _____

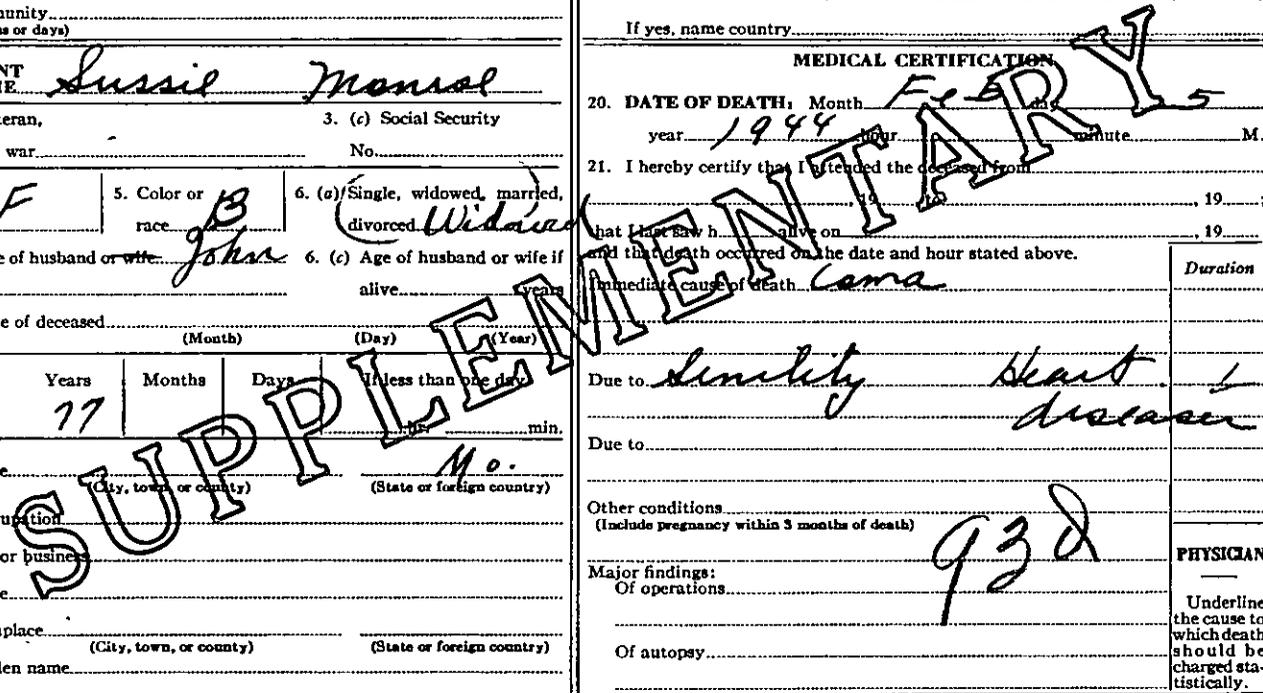
MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb Day 15 Year 1944 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____; _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Cama

Due to senility heart disease
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: 93d
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following: No
(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 H. J. Waigros (M. D. or other) _____
Address No. 1000 of State Date signed _____

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



MOTHER FATHER

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

15571