

3. No. 2  
4-13-40  
5-17-39  
I X23159

18726

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 18 1944

Registration District No. 237

Primary Registration District No. 5870 4353

Registrar's No. 12

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

1. PLACE OF DEATH: *New Madrid*  
 (a) County *New Madrid*  
 (b) City or town *Sedion*  
 (c) Name of hospital or institution: *1*  
 (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 *Missouri* (b) County *New Madrid*  
 (c) City or town *Sedion*  
 (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.

3. (a) PRINT FULL NAME *Mildred Louise Harrell*  
 3. (b) If veteran, name war *✓*  
 3. (c) Social Security No. *2*

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month *Feb* day *4*  
 year *44* hour *9* minute *30 A.M.*  
 21. I hereby certify that I attended the deceased from *Jan 28*  
 1944 to *Feb 4* 1944  
 that I last saw her alive on *Feb 3* 1944  
 and that death occurred on the date and hour stated above

4. Sex *fen* 5. Color or race *W*  
 6. (a) Single, widowed, married, divorced *0*  
 6. (b) Name of husband or wife *✓*  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: *Jan 28 44*  
 (Month) (Day) (Year)

Immediate cause of death *Jandouse Bone*  
*without Fall Dist.*  
 Duration *Birth*

8. AGE: Years \_\_\_\_\_ Months *7* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to *✓*  
 Due to *✓*  
 Other conditions *161C*  
 (Include pregnancy within 3 months of death)

9. Birthplace *Sedion* (City, town, or county) *MO* (State or foreign country)  
 10. Usual occupation *at infant*

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 Major findings: *✓*  
 Of operations \_\_\_\_\_  
 Of autopsy *✓*

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name *Harry Harrell*  
 13. Birthplace *Wagon Co* (City, town, or county) *MO* (State or foreign country)  
 14. Maiden name *May Harrell*  
 15. Birthplace *Cotton Wood Pt* (City, town, or county) *MO* (State or foreign country)

16. (a) Informant *Harry Harrell*  
 (b) Address *Malden Mo.*  
 17. (a) *Burial* (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

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 *9*

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) *Feb 5 44* (b) *Juda Maeon*  
 (Date received local registrar) (Registrar's signature)

23. Signature *Judson Custard* (M. D. or other)  
 Address *Malden* Date signed *Feb 4/44*

558

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2

District File Number 544-749

Date Filed 5-16-44

**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.**