

No. 2  
5-42  
17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUN 20 1944**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

22116

State File No. ....

Registration District No. 238

Primary Registration District No. 4355

Registrar's No. 18

**1. PLACE OF DEATH:**  
 (a) County New Madrid  
 (b) City or town New Madrid  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: No  
 (If not in hospital or institution, write street number or location) 1  
 (d) Length of stay: In hospital or institution No  
 In this community About 50 years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County New Madrid  
 (c) City or town New Madrid  
 (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** ZILDA MEIER  
 3. (b) If veteran name war No 3. (c) Social Security No. No.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month MAY day 21  
 year 1944 hour 7:30 minute 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 27 years  
 7. Birth date of deceased: MARCH 27 1860  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12/18, 1943, to 5/21, 1944; that I last saw her alive on 5/21, 1944; and that death occurred on the date and hour stated above.

**8. AGE:** Years 84 Months 1 Days 24 If less than one day hr. min.  
 9. Birthplace: ST. LOUIS (City, town, or county) No. 0 (State or foreign country)

Immediate cause of death Arteriosclerotic Heart Disease

10. Usual occupation UNEMPLOYED  
 11. Industry or business ✓  
**MOTHER FATHER**  
 12. Name EDWARD O'REILLY  
 13. Birthplace UNK (City, town, or county) UNK (State or foreign country)  
 14. Maiden name MARIE FRAGINE  
 15. Birthplace UNK (City, town, or county) UNK (State or foreign country)

Due to 93d  
 Due to 93d  
 Other conditions Unhealed fracture of neck of femur (1 yr)  
 (Include pregnancy within 3 months of death)  
 Major findings: Deafness - 20 yrs.  
 Of operations: Deafness - 20 yrs.

16. (a) Informant WALTER MEIER  
 (b) Address NEW MADRID, MO.  
 17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 22 1944 (Month) (Day) (Year)  
 (c) Place: burial or cremation EKEERENE  
 18. (a) Signature of funeral director Richard's Under  
 (b) Address NEW MADRID, MO.  
 19. (a) 5-24-44 (Date received local registrar) (b) Nelson Lead Jones (Registrar's signature)

Of autopsy ADDITIONAL SUPPLEMENTARY INFORMATION  
**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 W. J. Allen (M. D. or other) 5/21/44  
 Address New Madrid Date signed 5/21/44

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

RECEIVED

District Health Office No.

District File Number 644-88

Date Filed 6-14-42

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**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

*L. H. Hayslett*

Licensed Embalmer No.

3803

P. O. Address

*New Madrid 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. ....

Registration District No. 238

Primary Registration District No. 4355

Registrar's No. 18

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town New Madrid  
(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 years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Zelda Merri

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

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

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 \_\_\_\_\_ years

7. Birth date of deceased Mar. 27 186  
(Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, min.)

9. Birthplace \_\_\_\_\_  
(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) \_\_\_\_\_ (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County N. Madrid

(c) City or town New Madrid  
(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 \_\_\_\_\_ day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and the death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) no

(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

22116