

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

22679

FILED JUN 22 1944

Registration District No. 3323

Primary Registration District No. 3074

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None.  
(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 Scott 100  
(c) City or town Sikeston 5  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. Madys  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Rose Lee Lynn.

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

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

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

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

7. Birth date of deceased July 30, 1890  
(Month) (Day) (Year)

8. AGE: Years 46 Months 8 Days 16 If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name J. S. Baker.

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

14. Maiden name Nancy Ellison

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

16. (a) Informant Nicholas

(b) Address Sikeston MO.

17. (a) Burial (b) Date thereof 7/15/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Orville Hayslet

(b) Address Sikeston MO.

19. (a) 6/29/44 (b) Louis Tergent  
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17  
year 1944 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 11, 1944  
1944, 19\_\_\_\_, to April 11, 1944  
that I last saw him alive on April 11, 44, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate Cause of death Chronic liver 4/17/44  
Duration

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 125 fl

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. M. Hendig (M. D. or other) \_\_\_\_\_  
Address Sikeston MO. Date signed 7/25/44

1318

(Licensed Embalmer's Statement on Reverse Side)

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

20  
25

RECEIVED

District Health Office No. 2,

District File Number 644-903

Date Filed 6-20-44

JAN  
2 1958

APR 26 1949

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 *W. Bluff*

Licensed Embalmer No. 3474

P. O. Address Poplar Bluff

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. 333

Primary Registration District No. 3074

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Liberton  
(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 Rose Lee Lynn  
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 Married  
6. (b) Name of husband or wife Harley 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased July 30 1899  
(Month) (Day) (Year)

8. AGE: Years 46 Months 8 Days..... If less than one day..... min.

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

10. Usual occupation seam

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) Louise Largent  
(Date received local registrar) (Registrar's signature)

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 April year 1944 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that 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.....

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).....  
(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

22679