

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25266**

FILED AUG 11 1944

Registration District No. **2**

Primary Registration District No. **5825**

Registrar's No. **4356**

1. PLACE OF DEATH:

(a) County **New Madrid**  
(b) City or town **Cation**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **None Como Hosp.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **36 hrs**  
(Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME **DOCIE-IRENE-ARCHER**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **div**  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased **July 23 1944**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**36 hr. 5 min.**

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **Mrs. E. Archer**  
13. Birthplace **Memary Co. Tenn. State**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Estelene Siler**  
15. Birthplace **Hardyman Co. Tenn. State**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. E. Archer**  
(b) Address **Cation Mo**

17. (a) **Burial** (b) Date thereof **7-25-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Taylor Cemetery**

18. (a) Signature of funeral director **Walter H. Service**  
(b) Address **Parma, Mo**

19. (a) **July 26/44** (b) **Mrs. S. B. Rademacher**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**  
(c) City or town **Cation** (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24th**  
year **1944** hour **12:00** **midnight**

21. I hereby certify that I attended the deceased from **July 23 1944** to **July 24 1944**  
that I last saw him alive on **July 23 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pose cerebral hemorrhage** Duration

Due to **birth injury**

Due to **Small pelvis of mother**

Other conditions.  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **160 C**

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 **Geo. W. Huetts** (M. D. or other)  
Address **Parma Mo** Date signed **7/27/44**

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

RECEIVED

District Health Office No. 2,

District File Number 844-1985

Date Filed 8-9-44

**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.**