

S. No. 2
M-3-43
v. 3-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25859**

Registration District No. **333** Primary Registration District No. **2074** 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: 517 Park
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 577 1/2 life years, months or days

3. (a) PRINT FULL NAME Henniella Schumate Moore
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, widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 28 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____
12. Name Dr John L. Schumate
13. Birthplace St Louis Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name M. Bee
15. Birthplace Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Franklin Moore
(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof 5/14/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston City

18. (a) Signature of funeral director W. L. Welch Funeral Home
(b) Address Sikeston Mo

19. (a) 8/6/44 (b) Lerie Laegind
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott **100**
(c) City or town Sikeston **5**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. 517 Park
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1944 hour 3 minute 15 A. M.
21. I hereby certify that I attended the deceased from 8-19-43
19 _____ to May 12 1944
that I last saw W alive on May 12
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Duration 1 yr.
transverse colon
(Metastatic)

Due to Carcinoma **2 yr.**
of the uterus

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: H&P
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)
(c) Means of injury _____
23. Signature Thomas C. McClure
Address Sikeston, Mo Date signed 7-17-44

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

20
251

RECEIVED

District Health Office No 2,

District File Number 844-1094

Date Filed 8-10-44

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 Raymond Crews
Licensed Embalmer No. 3467
P. O. Address Sikeston 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.