

FILED SEP 13 1944

State File No. ....

Registration District No. 33300

Primary Registration District No. 3074

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Sikeston Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(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 Scott <sup>100</sup>  
(c) City or town Sikeston Mo. <sup>5</sup>  
(If outside city or town limits, write "RURAL") <sup>2</sup>  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ <sup>0</sup>

3. (a) PRINT FULL NAME Bettie Jean Waters  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 6  
year 1944 hour 2 minute 30 P.M.

4. Sex female 5. Color or race Colored 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 Aug 13 1944  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 1, 1944 to Sept 5, 1944  
that I last saw her alive on Sept 5, 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
1 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Lobar Pneumonia <sup>5 days</sup>  
Due to Influenza  
Due to \_\_\_\_\_

9. Birthplace Sikeston Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) B3a  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name John Waters  
13. Birthplace New Madrid Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Bernee Turner  
15. Birthplace Sikeston Mo  
(City, town, or county) (State or foreign country)

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 0

16. (a) Informant Mary Turner  
(b) Address Sikeston Mo  
17. (a) Burial (b) Date thereof 9 7 44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sunset Addition  
18. (a) Signature of funeral director Mattie Smith  
(b) Address 1381 Mand St. Sikeston, Mo.  
19. (a) 9/7/44 (b) Louise Largent  
(Date received local registrar) (Registrar's signature)

23. Signature Noble R. Frisby Md (M. D. or other) \_\_\_\_\_  
Address 1381 Mand St. Date signed 9-7-44

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 944-1262

Date Filed 9-12-44

---

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.**