No. 2
5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 19 1944
Ferguson 333

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35446
State File No.

Registration District No. Benton Mo. 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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community 15 years

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

3. (a) PRINT FULL NAME Nora Lee Lynn
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex 1 F
5. Color or race W
6. (a) Single, widowed, married, divorced M 1
6. (b) Name of husband or wife Denton Lynn
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 4 (Month) 22 (Day) 1896 (Year)

8. AGE: Years	Months	Days	If less than one day
49	4	21	hr. min.

9. Birthplace (City, town, or county) 4 (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name John Hensley
13. Birthplace (City, town, or county) Tenn. 1 (State or foreign country)
MOTHER 14. Maiden name Elizabeth Burns
15. Birthplace (City, town, or county) Ky. 1 (State or foreign country)
16. (a) Informant Denton Linn
(b) Address Sikeston Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/44 (Month) (Day) (Year)
(c) Place: burial or cremation Morley Mo.
18. (a) Signature of funeral director H. W. Albritton
(b) Address Sikeston Mo.
19. (a) 10-11-44 (Date received local registrar) (b) Lance Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13 year 1944 hour 11 minute 55 A.M.
21. I hereby certify that I attended the deceased from Nov 1, 1943 to Sept. 13, 1944 that I last saw her alive on Sept. 13, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertrophy + Dilitation Heart	
Due to Mitral Stenosis + Aortic Regurgitation	
Due to	
Other conditions Edema Lungs, abdomen + Limbs 1 Yr (Include pregnancy within 3 months of death)	

Major findings:
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? (Specify type of place)
While at work?
(e) Means of injury
23. Signature A. P. Ferguson (M. D. or other)
Address Benton Mo. Date signed 9/14/44

1518 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 1044-1410
Date Filed 10-18-44

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 .....

Embalmed, Registered Apprentice No. .....

working under my personal supervision.

Signed John Allenton

Licensed Embalmer No. 2941

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.

. No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. None

Registration District No. 333 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:

(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

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

3. (a) PRINT FULL NAME Nora 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 M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 22 1894
(Month) (Day) (Year)

8. AGE: Years 49 Months 4 Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 3 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

35446