

Linson

38970

State File No.

FILED DEC 14 1944
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:
520 E. Matthews St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *1* (Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME *SHARON VIOLET TOWNSEND*
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, *single*
6. (b) Name of husband or wife 6. (c) Age of husband or wife if
alive years
7. Birth date of deceased *Sept 11 1942*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 2 5 hr. min.

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

10. Usual occupation *Baby*

11. Industry or business

MOTHER FATHER { 12. Name *W.P. Townsend*
13. Birthplace *Mt Vernon Ind*
(City, town, or county) (State or foreign country)
14. Maiden name *Mary Glenn*
15. Birthplace *Shannon Co Mo*
(City, town, or county) (State or foreign country)

16. (a) Informant *Mrs Mary Townsend*
(b) Address *Sikeston Mo*

17. (a) *Burial* (b) Date thereof *12-5-44*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Matthews Mo*

18. (a) Signature of funeral director *Walter General Home*
(b) Address *Sikeston Mo*

19. (a) *12/12/44* (b) *Louis Largent*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Mo* (b) County *Scott Mo*
(c) City or town *Sikeston*
(If outside city or town limits, write "RURAL")
(d) Street No. *520 Matthews Mo 2*
(If rural, give location)
(e) Citizen of foreign country? *NO* (Yes or No)
If yes, name country *11*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *4*
year *1944* hour *6* minute *00* A. M.
21. I hereby certify that I attended the deceased from *11-25* 19 *44* to *12-2-44*
that I last saw her alive on *12-2-44* 19 *44*
and that death occurred on the date and hour stated above.

Immediate cause of death *Influenza* Duration *9 days*

Due to *33h*

Other conditions (Include pregnancy within 3 months of death) *Bronchitis*

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?

While at work? *At home* (Specify location of place) (a) Means of injury *fall*
23. Signature *F. L. Linson* (M. D. or other)
Address *Sikeston Mo* Date signed *12-11-44*

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

RECEIVED

District Health Office No. 2,

District File Number 124-1635

Date Filed 12-13-44

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... Shelton 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.