

No. 2
-8-43
5-17-39
X37823

FILED JAN 19 1945

Registration District No. 240

Primary Registration District No. 5827

Registrar's No. 140

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Lewis Twp - Rural
(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 _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid
(c) City or town Rural - Lewis Twp -
(If outside city or town limits, write "RURAL")
(d) Street No. (Lilbourn, MO)
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mamie Mmaweathers

3. (b) If veteran, name war X (c) Social Security No. _____

4. Sex F-3 5. Color or race col 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Harrison Mmaweathers 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased 10-16-91
(Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jan Lillard

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

14. Maiden name Nancy Jim

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

16. (a) Informant Harrison Mmaweathers
(b) Address P-1 P O Box 710

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

(c) Place: burial or cremation Sand Hill

18. (a) Signature of funeral director W. H. White
(b) Address Lilbourn Mo
19. (a) 1-10-45 (b) Mrs. J. L. Parrett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5 year 45 hour 7 minute 4 M.

21. I hereby certify that I attended the deceased from Jan 4 1945 to Jan 5 1945; that I last saw her alive on Jan 5 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____
Due to 83a

Other conditions Essential Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 E. E. Jones (M. D. or other) _____
Address Lilbourn Mo Date signed 1-6-45

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

MOTHER FATHER

32-8
-45

EB 20 1945

RECEIVED

District Health Office No. 2,

District File Number 145-~~116~~ 49

Date Filed 1-15-45

JAN 22 1945

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 *J. H. Hill*

Licensed Embalmer No. 8027

P. O. Address Libbourn 910

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.

Registration District No. 240

Primary Registration District No. 5827

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Lewis Twp. Rural
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Marnie Munawather

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race B

6. (a) Single, widowed, married, divorced mar

6. (b) Name of husband or wife Hans

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased no (Month) 17 (Day) 1917 (Year)

8. AGE: Years 63 Months 1 Days 1 Unless than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

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) 1-10-45 (Date received local registrar) (b) Mr. J. L. Farret (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1945 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

