S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.: 6831

Registration District No. 269 Primary Registration District No. 5908 Registrar's No.

1. PLACE OF DEATH:
(a) County Pemiscott Mo.
(b) City or town Hemondale Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Holland Dairy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 1937 years, months or days)

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

3. (a) PRINT FULL NAME Lucy Wilkerson
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or Col.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 2 (Day) 1868 (Year)

8. AGE: Years 77 Months Days If less than one day hr. min.

9. Birthplace Georgia (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Same
FATHER 12. Name Charles Norman
13. Birthplace Dout Knox (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Dakery Ann
15. Birthplace Dout Knox (City, town, or county) (State or foreign country)
16. (a) Informant Lillie B. Grant
(b) Address Blytheville Ark.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Hemondale Mo.
18. (a) Signature of funeral director Frasley & Cobb
(b) Address Blytheville Ark.
19. (a) 3-6-45 (Date received local registrar) (b) C. C. Limbaugh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31 1945 year 1945 hour 5 minute 20 A.M.
21. I hereby certify that I attended the deceased from Jan 19th, 1945, to Jan 31, 1945 that I last saw her alive on Jan 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Due to
Due to
Other conditions Bronchitis (Include pregnancy within 3 months of death)
Major findings: Of operations none
Of autopsy no

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) none
(b) Date of occurrence none
(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 0
23. Signature B. E. Roberts MD (M. D. or other)
Address Blytheville Date signed 2-3-45

1201

(Licensed Embalmer's Statement on Reverse Side)

2-45-55

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 me

Jan-31-1945-, Registered Apprentice No.

working under my personal supervision.

Signed W. F. Cobb

Licensed Embalmer No. 409-

P. O. Address Blytheville Ark

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.