No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10344

Registration District No. 271 Primary Registration District No. 591 Registrar's No.

1. PLACE OF DEATH:
(a) County Pemiscot
(b) City or town Rural Pascola twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pemiscot
(c) City or town Rural Pascola twp
(If outside city or town limits, write "RURAL")
(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 Annie B Jeanes
3. (b) If veteran, name war ✓
3. (c) Social Security No. /

4. Sex F 3
5. Color or race Col
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Oct (Month) 22 (Day) 1871 (Year)

8. AGE: Years 73 Months 3 Days 1 If less than one day hr. min.

9. Birthplace Batesville (City, town, or county) Miss (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name Bat Heron
13. Birthplace (City, town, or county) Miss (State or foreign country)
MOTHER 14. Maiden name DK
15. Birthplace DK (City, town, or county) (State or foreign country)
16. (a) Informant Ples Smith
(b) Address Bragg City Mo Rt 1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation Wardell Mo
18. (a) Signature of funeral director German Funeral Home
(b) Address Steele Mo
19. (a) 4-2-45 (Date received local registrar) (b) Mrs P. R. Cole (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23
year 1945 hour 2:00 minute A. M.
21. I hereby certify that I attended the deceased from Feb 1944 to 1-20- 1945
that I last saw her alive on 1-20 — 1945
and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Pulmonary Pneumonia	about 1 wk
Due to:	
Due to:	
Other conditions: Paralysis since Feb '44 (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Dr J L Masters (M. D. or other)
Address Hayti Mo Date signed 1-23-45

591 (Licensed Embalmer's Statement on Reverse Side)

3-45-59

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 John W Sherman

Licensed Embalmer No. 4355

P. O. Address Steele, 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
M—3-45
P I X43880

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

2nd query

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10344

Registration District No. 271 Primary Registration District No. 5911 Registrar's No.

1. PLACE OF DEATH:
(a) County Pemiscot
(b) City or town 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 (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 Annie B. James
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 22 (Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Miss (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: (Month) January (Day) 23
year 1945 (hour) minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Lobar Pneumonia — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION RECEIVED
Of autopsy No

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 L Masters M.D.
Address Hayti Mo Date signed 3-29-45