

S. No. 2
A-5-42
5-17-39
P1 X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13056

State File No.

Registrar's No. 110.

FILED MAY 10 1945
Registration District No. 3010

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU

(b) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1431 WAYNE ST !
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community 66 YRS. About 6 mo. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County CAPE GIRARDEAU

(c) City or town CAPE GIRARDEAU 16
(If outside city or town limits, write "RURAL")

(d) Street No. 1431 WAYNE ST !
(If rural, give location) 4

(e) Citizen of foreign country? NO 12 (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME ELIZIBETHANE MILLER

3. (b) If veteran, name war.....

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1945 hour about 4 minute 9: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.

4. Sex FEMALE 5. Color or race WHITE

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. JAN. 31 1879
(Month) (Day) (Year)

Immediate cause of death Malnutrition Duration.....

8. AGE: Years 66 Months 2 Days 10 If less than one day hr. min.

Due to Pulmonary Tuberculosis

Due to.....

9. Birthplace COMMERCE MO. (1)
(City, town, or county) (State or foreign country)

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

Major findings:
Of operations.....

10. Usual occupation HOUSEWIFE

11. Industry or business.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name CHAS. CUNNINGHAM

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

14. Maiden name DONT KNOW

15. Birthplace DONT KNOW 9
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. GROVER SMITH

(b) Address FORNELT MO.

17. (a) BURIAL (b) Date thereof 4-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LIGHTNER ILLMO MO.

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?.....

18. (a) Signature of funeral director BISPLINGHOFF-HUBBARD

(b) Address ILLMO MO.

19. (a) 4-13-45 (b) B. H. Phelps
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) Means of injury.....

23. Signature Dr. J. F. Sigmon (M. D. or other) Coroner

Address Jacobson, Mo. Date signed 4/11/45

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

1014

02
RECEIVED

District Health Officer No. 4

District File Number 545-580

Date Filed 5-7-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

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