

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Portageville  
(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 Missouri (b) County New Madrid

(c) City or town Portageville 72  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 60

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joe Ford

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 9. Color or race Black

5. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

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

Unknown hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Coroner

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof Apr 9, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Portageville

18. (a) Signature of funeral director: De Lisle Funeral Parlor

(b) Address Portageville, Mo

19. (a) 4-8-45 (b) Elmer De Lisle  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6  
year 1945 hour 8:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death: Shot with shot gun in left arm, shot in chest

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy No 166

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) Homicide

(b) Date of occurrence April 6, 1945

(c) Where did injury occur? New Madrid, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place (Specify type of place)

While at work? No (e) Means of injury Shot

23. Signature Highsmith 3  
Address New Madrid, Mo 3 (M.D. or other)

Date signed 4/8-45

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

22  
16  
0

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 545-64

Date Filed 3-7-4

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 <sup>Not</sup>....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Leonard John Vargo*

Licensed Embalmer No. 4386

P. O. Address Portageville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *may*

Registration District No. *241*

Primary Registration District No. *4360*

Registrar's No. *f*

1. PLACE OF DEATH:

(a) County *new medic*  
(b) City or town *Portageville*  
(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

*Joe Ford*

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

3. (c) Social Security No.....

4. Sex *M*

5. Color or race *B*

6. (a) Single, widowed, married, divorced *(Unknown)*

6. (b) Name of husband or wife *(Unknown)*

6. (c) Age of husband or wife if alive *(Unknown)*

7. Birth date of deceased (Month) (Day) (Year)

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

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

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *12* year *19* hour *55* minute *16* M.

21. I hereby certify that I attended the deceased from *12/19/55* to *12/19/55*; that I last saw him *alive* on *12/19/55* and that death occurred on the date and hour stated above. Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

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? (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

14073