

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17632**

Registration District No. **229**

Primary Registration District No. **5825**

Registrar's No. **4256**

1. PLACE OF DEATH:

(a) County **New Madrid**

(b) City or town **Caton (Cora Junction)**

(c) Name of hospital or institution: **No.**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **No.**

In this community **About 5 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**

(c) City or town **Caton, Mo. 15**

(If outside city or town limits, write "RURAL")

(d) Street No. **0**

(If rural, give location)

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

If yes, name country.

3. (a) PRINT FULL NAME **ANNE CONAWAY**

(b) If veteran, name war **No.**

(c) Social Security No. **No.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **24**

year **1942** hour **10:40** minute **P.** M.

4. Sex **Female**

5. Color or race **Black**

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

(b) Name of husband or wife **UNK.**

(c) Age of husband or wife if alive **15** years

7. Birth date of deceased **11-15-1882**

(Month) (Day) (Year)

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.

8. AGE:

Years	Months	Days	If less than one day
62	5	9	hr. min.

Immediate cause of death **No Medical Attendant by all record death**

Due to **was due**

Due to **Cancer of the Right Breast about 1 year.**

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace **St. Joe La. 1**

(City, town, or county) (State or foreign country)

Major findings:

Of operations **NO**

Of autopsy **NO**

10. Usual occupation **None**

11. Industry or business **✓**

12. Name **H. M. Marshall**

13. Birthplace **unk La 1**

(City, town, or county) (State or foreign country)

14. Maiden name **Mary Boyd**

15. Birthplace **unk La 1**

(City, town, or county) (State or foreign country)

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 **Leo Hedgwith - Coroner**

(M.D. or other)

Address **New Madrid Mo.** Date signed **4/26**

16. (a) Informant **Mamie Hopkins**

(b) Address **Caton, Mo.**

17. (a) **Burial** (b) Date thereof **4-29-45**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **land hill**

18. (a) Signature of funeral director **Richard and Co**

(b) Address **New Madrid Mo.**

19. (a) **4-29-45** (b) **Dr. Courtland**

(Date received local registrar) (Registrar's signature)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

12000

1396

45

RECEIVED
District Health Office No. 2,
District File Number 545-733
Date Filed 5-11-45

MAY 19 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 Leo Hudgyneth
Licensed Embalmer No. 3803
P. O. Address New Madrid, 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.