

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20890

State File No.

Registrar's No.

FILED JUL 12 1945 38

Primary Registration District No.

4355

88

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(If outside city or town limits, write "RURAL" and name of township)
(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
(Specify whether)
In this community all of life
years, months or days

3. (a) PRINT FULL NAME ORA LEE ABBOTT

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased April 6 - 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 25 hr. min.

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

10. Usual occupation Child

11. Industry or business ✓

MOTHER FATHER { 12. Name Bill Abbott
13. Birthplace unk Mo. 2
(City, town, or county) (State or foreign country)
14. Maiden name Billie Belle Adams
15. Birthplace unk Ark 1
(City, town, or county) (State or foreign country)

16. (a) Informant Bill Abbott
(b) Address New Madrid, Mo.
17. (a) Burial (b) Date thereof, 5-31-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Evergreen

18. (a) Signature of funeral director Richardson and Co
(b) Address New Madrid, Mo.
19. (a) 6-18-45 (b) Edw. L. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town New Madrid 19
(If outside city or town limits, write "RURAL")
(d) Street No. 4
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1945 hour 8:00 minute P. M.
21. I hereby certify that I attended the deceased from May 24
May, 1945, to May 31, 1945;
that I last saw her alive on May 24, 1945;
and that death occurred on the date and hour stated above.
Immediate cause of death ✓
Distro-Enteritis Duration 4 wks

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?
(Specify type of place)
While at work? (e) Means of injury.....
23. Signature E. E. Jones (M. D. or other) 0
Address Libbourn Mo Date signed 6-4-45

RECEIVED

District Health Office No. 2

District File Number 745-940

Date Filed 7-11-45

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed

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.