S. No. 2
—9-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

Registration District No. 238

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4355

State File No. 20891

Registrar's No. 83

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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town New Madrid 12
(If outside city or town limits, write "RURAL")
(d) Street No. 4
(If rural, give location) 6
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ORVILLE D. ABBOTT

3. (b) If veteran, name war No

3. (c) Social Security No. No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased APRIL 5 (Month) (Day) 1945 (Year)

8. AGE: Years | Months 1 | Days 15 | If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Bill Abbott
13. Birthplace (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Lillie Dame
15. Birthplace (City, town, or county) Ark. (State or foreign country)

16. (a) Informant Bill Abbott
(b) Address New Madrid Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Evergreen

18. (a) Signature of funeral director Richards and Co
(b) Address New Madrid Mo

19. (a) 5-29-45 (Date received by local registrar) (b) Helen Loudermilk (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
year 1945 hour 1:00 minute a M.

21. I hereby certify that I attended the deceased from May 14, 19 45 to , 19 ;
that I last saw him alive on May 14, 19 45
and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Bronchopneumonia	
Due to:	
Due to:	
Other conditions: Prematurity (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 P. Fellenzer MD (M. D. or other)
Address New Madrid Date signed 5/29/45

1368

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 645-854
Date Filed 6-12-65

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 Not Embalmed

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.