S. No. 2
—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20892

Registration District No. JUL 12 1945 2328

Primary Registration District No. 5827

Registrar's No. 94

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Matthews, Mo. Rfd. # 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no Big Prairie Nursery
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 3 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Matthews Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Rfd # 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country -

3. (a) PRINT FULL NAME Roosevelt Artis
3. (b) If veteran, name war no
3. (c) Social Security No. -

4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife X
6. (c) Age of husband or wife if alive X years
7. Birth date of deceased May (Month) 22 (Day) 1924 (Year)

8. AGE: Years	Months	Days	If less than one day
20	11	15	- hr. - min.

9. Birthplace Malden (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farm Hand
11. Industry or business -

MOTHER / FATHER
12. Name John Artis
13. Birthplace North Carolinia (City, town, or county) (State or foreign country)
14. Maiden name Betty Unknown
15. Birthplace Atlanta Ga. (City, town, or county) (State or foreign country)

16. (a) Informant Hessie Lee Bowden
(b) Address Sikeston, Mo. Gen. Del
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/45 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Cemetary Sikeston Mo.
18. (a) Signature of funeral director John Chiles
(b) Address Sikeston Mo.
19. (a) June 15 1945 (Date received local registrar) (b) Delia Land Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1945 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from 5/1/45, 19.., to 5/7/45, 19..;
that I last saw h.. alive on .., 19..;
and that death occurred on the date and hour stated above.

Immediate cause of death	Broken neck		Duration
Due to	Drowned		
Due to			
Other conditions (Include pregnancy within 3 months of death)			
Major findings: Of operations			
Of autopsy			

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 7-17-45

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) Accident
(b) Date of occurrence 5/7/45
(c) Where did injury occur? Matthews (City or town) New Madrid (County) Mo. (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 Drowned

23. Signature D. McMillan (M. D. or other)
Address Sikeston Mo. Date signed 7/9/45

1567 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 45-245
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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed John Allen

Licensed Embalmer No. 2941

P. O. Address Sikeston, 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.