

S. No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21497
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 10 1945
Registration District No. 333

Primary Registration District No. 3074

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

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 4 yr. years, months or days

3. (a) PRINT FULL NAME Mary T. W. Britton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W
6. (a) Single widowed, married, divorced 9
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Mar 10 - 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation House work

11. Industry or business _____

MOTHER FATHER
12. Name Thomas Payne
13. Birthplace Ark (City, town, or county) (State or foreign country)
14. Maiden name Wk
15. Birthplace Wk (City, town, or county) (State or foreign country)

16. (a) Informant Lola Litchford

(b) Address Sikeston South Side

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield

18. (a) Signature of funeral director Louise Tom

(b) Address Campbell St

19. (a) 6/29/45 (Date received local registrar) (b) Louis Legend (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott
(c) City or town Sikeston (If outside city or town limits, write "RURAL") 101
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10 year 1945 - hour 4 minute 9 A.M.
21. I hereby certify that I attended the deceased from 6-6-45 19____ to 6-10-45 19____ that I last saw her alive on 6-6-45 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 day
Generalized Arterio Sclerosis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations None
Of autopsy _____
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 H. M. Legend (M. D. or other)
Address Sikeston Mo Date signed 6-14-45

1314

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No.

District File Number 745-2

Date Filed 7-6-45

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 *E. W. Rander*.....

Licensed Embalmer No. 2289.....

P. O. Address *Amphlett, 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.