

FILED AUG 13 1945  
Registration District No. **53**

Primary Registration District No. **3010**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**  
(b) City or town **Cape Girardeau**  
(c) Name of hospital or institution: **South East Hospital**  
(d) Length of stay: In hospital or institution **4 months**  
In this community **2 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ballingue**  
(c) City or town **Lutesville Mo**  
(d) Street No. **0**  
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Rebecca Josephine Hales**

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

4. Sex **Female** 5. Color or race **co** 6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Oct 22 - 1865**

8. AGE: Years **79** Months **9** Days **20** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Sedgewickville Mo. D**

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **Wm Masters**

13. Birthplace **Mo**

14. Maiden name **DK**

15. Birthplace **DK**

16. (a) Informant **Java C. Estes**

(b) Address **Cape Girardeau Mo**

17. (a) **Burial** (b) Date thereof **July 13 - 45**

(c) Place: burial or cremation **Maple Hill Mo**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **12** year **1945** hour **5 am** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **July 2** to **July 12**, 19**45**

that I last saw **her** alive on **7/12**, 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Hypertension**

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **g hnd**

Of autopsy \_\_\_\_\_

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 **[Signature]** (M. D. or other) \_\_\_\_\_ Date signed **7/14/45**

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4  
District File Number 845-993  
Date Filed 8-10-45

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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

*W. H. Estes*

Licensed Embalmer No.

*3568*

P. O. Address

*Cape San Marcos*

**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.