

No. 2
M-2-43
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33412

State File No. _____

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 324

1. PLACE OF DEATH:

(a) County Cape Girardeau Mo

(b) City or town Cape Girardeau Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Southwest Missouri Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hrs.
(Specify whether years, months or days)

In this community 12 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Cape

(b) City or town Cape Girardeau Missouri
(If outside city or town limits, write "RURAL")

(c) Street No. 0
(If rural, give location)

(d) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Cathleen Opal Jamin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 10 (Month) 2 (Day) 45 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 12 hrs. min.

9. Birthplace Cape Girardeau Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name George Jamin

13. Birthplace Maryland Mo
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rogers

15. Birthplace Boston Mass
(City, town, or county) (State or foreign country)

16. (a) Informant Edw Jamin

(b) Address Maryland Mo

17. (a) Burial (b) Date thereof 10-3-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maryland Mo.

18. (a) Signature of funeral director Edw Jamin

(b) Address Maryland Mo.

19. (a) 10-2-45 (b) F. H. Phelps
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 2 year 1945 hour 5 minute P.M.

21. I hereby certify that I attended the deceased from 10-2- 1945 to 10-2- 1945; that I last saw her alive on Oct 2nd 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Weakness due to premature birth, which was 6 mo. pregnancy.

Due to _____

Due to _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Major findings: Of operations 159

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)

(c) Means of injury _____

23. Signature Edw. Crites (M. D. position) _____

Address Sedgewick Hall Date signed 10/3/45

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

1019

Health Officer No. 4
District File Number 1045-1214
Date Filed 10-23-45

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.....

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.