

FILED DEC 38 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 3010

Registrar's No. 359

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU
(b) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. FRANCIS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether years, months or days)
In this community 16 days

3. (a) PRINT FULL NAME

BOBBIE JOE ALEXANDER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M D 5. Color or race W 6. (a) Single, widowed, married, divorced INFANT
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased OCT 20 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 16 If less than one day hr. _____ min.

9. Birthplace CAPE GIRARDEAU MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business INFANT

12. Name DON'T KNOW

13. Birthplace DON'T KNOW
(City, town, or county) (State or foreign country)

14. Maiden name VIOLA ALEXANDER

15. Birthplace PARMA MO
(City, town, or county) (State or foreign country)

16. (a) Informant VIOLA ALEXANDER

(b) Address CAPE GIRARDEAU MO

17. (a) BURIAL (b) Date thereof NOV 5 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FAIRMOUNT CEM.

18. (a), Signature of funeral director HARVEY F. HOME

(b) Address CAPE GIRARDEAU MO

19. (a) 11-9-1945 (b) C. C. Summer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CAPE GIRARDEAU
(c) City or town CAPE GIRARDEAU
35A N. MAIN (If outside city or town limits, write "RURAL")
(d) Street No. ST. FRANCIS HOSPITAL
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 5
year 1945 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from 10/25
1945 to 11/5 1945
that I last saw him alive on 11/5 1945
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

TRIMETERY
(7 1/2 MONTHS)
Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy 15
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 at D. Smith (M. D. or other) MD

Address CAPE GIRARDEAU Date signed 11/6/45

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

RECEIVED

Public Health Officer No. 4

District File Number 1245-13

Date Filed 12-6-45

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.....

Licensed Embalmer No. 3598

P. O. Address Cape Girardeau, 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.