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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36813

FILED DEC 8 1945

Registration District No. 3 Primary Registration District No. 3010 Registrar's No. 386

16
4

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

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(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: St Francis ~~3 days~~ Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (specify whether years, months or days)
In this community 3 Days

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

3. (a) PRINT FULL NAME: Alice Hall
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: no
4. Sex: Female
5. Color or race: Colored
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: Nov (Month) 10 (Day) 1905 (Year)

8. AGE: Years 40 Months 0 Days 16 If less than one day hr. min.

9. Birthplace: unknown (City, town, or county) unknown (State or foreign country)
10. Usual occupation: Housework
11. Industry or business:
MOTHER FATHER
12. Name: unknown
13. Birthplace: unknown (City, town, or county) unknown (State or foreign country)
MOTHER
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) unknown (State or foreign country)
16. (a) Informant: Mrs Cope
(b) Address: Sikeston Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Sunset Cemetery
18. (a) Signature of funeral director: Orville Taylor
(b) Address: Sikeston Mo
19. (a) 12-1-1945 (Date received local registrar) (b) T. C. Summers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26 year 1945 hour 6 minute 45 A. M.
21. I hereby certify that I attended the deceased from Nov 24, 1945, to Nov 26, 1945; that I last saw her alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diabetic Coma	?
Due to: Diabetes mellitus	?
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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: R. J. Ritter, M.D. (M. D. or other)
Address: Cape Girardeau Mo Date signed 11-29-45

1509

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District 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. 3474

P. O. Address Poplar Bluff

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.