

FILED NOV 28 1945
Header

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. **37**

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: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 31 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 216 MOORE AVE.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 9
year 1945 hour 9 minute A.M.

21. I hereby certify that I attended the deceased from September 25, 1945 to October 6, 1945;
that I last saw her alive on October 6, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia, Cystitis- contributing cause. Duration 4 days

Due to _____

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? _____

While at work? _____ (Specify type of injury) (e) Means of injury _____

23. Signature [Signature] (Date received) 10-16-45
Address Sikeston, Missouri Date signed 10-16-45

3. (a) PRINT FULL NAME

Sophia McGilvary

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced M /

6. (b) Name of husband or wife R.W. McGilvary 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased 9 (Month) 13 (Day) 1874 (Year)

8. AGE: Years 71 Months 0 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace New Douglas Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Ekhoft

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

14. Maiden name Margaret Renkin

15. Birthplace McCoupin Co. Ill. (City, town, or county) (State or foreign country)

16. (a) Informant R.W. McGilvary

(b) Address Sikeston, Mo.

17. (a) Burial (b) Date thereof 10/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston, Mo.

19. (a) 11-5-45 (b) Mrs T.F. Henry
(Date received local registrar) (Registrar's signature)

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

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5
2

147

RECEIVED

District Health Office No. 2

District File Number 1195-325

Date Filed 11-9-45

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.....

.....Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed John Allerton

Licensed Embalmer No. 2941

P. O. Address Sikeston, 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.