. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

42598

State File No.

FILED JAN 8 1946

Registration District No. 335 Primary Registration District No. 6118 Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Oran - rural Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
In this community —
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Flossie Adams
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex fem
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife —
6. (c) Age of husband ~~or wife~~ if alive 40 years
7. Birth date of deceased Aug (Month) 2 (Day) 1921 (Year)

8. AGE: Years 24 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Whiteville R F D. Tenn (City, town, or county) (State or foreign country)
10. Usual occupation House wife
11. Industry or business "
MOTHER FATHER
12. Name Will Watson
13. Birthplace Tenn (City, town, or county) (State or foreign country)
14. Maiden name Dont Know
15. Birthplace " (City, town, or county) 9 (State or foreign country)
16. (a) Informant Leo Watson
(b) Address Oran Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/11 45 (Month) (Day) (Year)
(c) Place: burial or cremation Brownsville Tenn
18. (a) Signature of funeral director Clyde Mashburn
(b) Address Brownsville, Tenn. Funeral Home
19. (a) Jan 2-46 (Date received local registrar) (b) G. E. Coleman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11
year 1945 hour 6 minute 15 A.M.
21. I hereby certify that I attended the deceased from May, 1945, to 12/11, 1945
that I last saw her alive on 12/10 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diabetes Mulitis	9
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 followings
(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 J. A. Clone (M. D. or other)
Address Oran Mo Date signed 1/4/46

732 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 146 - 3
Date Filed 1-14-46

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.

X Signed Clyde Mackburn Jr.

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.