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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 11 1946**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10305

State File No. \_\_\_\_\_  
Registrar's No. 22

Registration District No. \_\_\_\_\_ Primary Registration District No. 6908

1. PLACE OF DEATH  
(a) County Clay  
(b) City or town Rural Holland Miss  
(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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Tenn (b) County Chester  
(c) City or town Chester  
(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 Angie Massingill  
3. (b) If veteran, name war NO  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 2 day 14  
year 1946 hour 4 minute 20 P.M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from Jan 22  
1946 to Feb 14 1946  
that I last saw her alive on Feb 13 1946  
and that death occurred on the date and hour stated above.

7. Birth date of deceased Don't Know  
(Month) (Day) (Year)  
8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death trauma  
Duration 3-4

9. Birthplace Chester County Tennessee  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired

Due to Cardiac hypertrophy & regurgitation  
Due to hypertension  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Smith  
13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Don't know  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant G. L. Russell  
(b) Address Holland, Mo  
17. (a) Removal (b) Date thereof 2-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sweetie's Cemetery  
18. (a) Signature of funeral director Margie Guy Stone  
(b) Address Henderson Tenn  
19. (a) 4-1-46 (b) A. O. Russell  
(Date received from registrar) (Registrar's signature)

22. If death was due to external cause, 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)  
(e) Means of injury \_\_\_\_\_  
23. Signature Dr. G. L. Russell (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 2/14/46

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

3-46-85

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**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 272Primary Registration District No. 1908Registrar's No. 22

## 1. PLACE OF DEATH:

(a) County Pemiscot  
(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT  
FULL NAME Angie Massingill3. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security  
name war \_\_\_\_\_ No. \_\_\_\_\_4. Sex F 5. Color or race W 6. (a) Single, widowed, married  
divorced wid6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_)9. Birthplace Sen  
(City, town, or county) (State or foreign country)

## 10. Usual occupation \_\_\_\_\_

## 11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 1946  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from Jan 22  
1946 until Feb 13 1946  
that I last saw her alive on Feb 13 1946  
and that death occurred on the date and hour stated above.  
Immediate cause of death hypostatic pneumonia Duration \_\_\_\_\_Due to hypertension \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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)  
(e) Means of injury \_\_\_\_\_23. Signature Dr. England \_\_\_\_\_ (No. or other) 2  
Stuck \_\_\_\_\_ Date signed 4/16/46

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

SUPPLEMENTARY

MOTHER FATHER

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

10305