

27987

DEPARTMENT OF COMMERCE.
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 12 1946

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Pike County Hospital
(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

Bessie Atkins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F / 5. Color or race _____ 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. 7 1880
(Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Pike Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Telephone operator

11. Industry or business _____

12. Name Wm. D. Atkins
13. Birthplace _____
14. Maiden name Glenn Johnson
15. Birthplace Pike Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Acker
(b) Address Eolia Mo

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Eolia Cemetery

18. (a) Signature of funeral director NE Gooch
(b) Address Eolia Mo

19. (a) July 25 1946 NE Gooch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike 82
(c) City or town Eolia 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1946 hour 6 minute 30 a.m.
21. I hereby certify that I attended the deceased from 7-1-46 to 7-24 1946
that I last saw her alive on 7-24-46 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism
Due to PNEUMONIA and EMPHYSEMA
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 place) (e) Means of injury _____

23. Signature Chas. H. Lemellen (M. D. _____)
Address Louisiana Mo Date signed 7-24-46

(Licensed Embalmer's Statement on Reverse Side)

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

255

FEB 5 1947

RECEIVED
District Health Officer No. 10
District File Number 9-46-1709
Date Filed SEP 11 1946

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 Norman E. Gooch

Licensed Embalmer No. 2342

P. O. Address Eslio me

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. 27987

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Pike
 (b) City or town Louisa
 (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 NAMEBeessie Atkins

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

4. Sex _____ 5. Color or _____
 race _____ 6. (a) Single, widowed, married,
 divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased _____
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day)
65 hr. _____ min.

9. Birthplace _____
 (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 _____
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
 to _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

- Due to Bronchia

- Due to Pneumonia

- 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 Thos. H. Russell (M. D. or other)

- Address Louisa, Mo. Date signed 12-31-46

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

2682

FEB 5 1947