

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED DEC 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43208

State File No. _____

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 83

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:
333 S. Kingshighway 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 life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100
(c) City or town Sikeston 5
(If outside city or town limits, write "RURAL")
(d) Street No. 333 S. Kingshighway 2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SUSAN JANE KENDALL

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mr. D. E. Kendall 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 23 1857
(Month) (Day) (Year)

8. AGE: Years 89 Months 1 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Levi D. Chaney 9

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

14. Maiden name Mary Nealey 9

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs A C Sikes

(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof 10-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo City

18. (a) Signature of funeral director Welsh P. Horn

(b) Address Sikeston Mo

19. (a) 12-9-46 (b) Mrs D. F. Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
year 1946 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from March 15
1946, to Oct. 4 1946;
that I last saw him alive on Oct. 4 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis, generalized
Due to Senility

Duration
2 days

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 place)
(c) Means of injury _____

23. Signature P. D. Martin (M. D. or other) MD
Address Sikeston, Mo Date signed 11-13-46

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1246-1438

Date Filed 12-12-46

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.

Signed Raymond Crews

Licensed Embalmer No. 3467

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.