

No. 2
8-43
5-1-39
KX7823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Mellor
43212
State File No. _____
Registrar's No. 87

Registration District No. 333 Primary Registration District No. 3074

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: N. West St 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. N. West St 3
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JUNE JANETTE WESTMORELAND
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 14
year 1946 hour 3 minute 45 A.M.
21. I hereby certify that I attended the deceased from March 11, 1946 to _____, 19____;
that I last saw her alive on 13 Nov 46, 19____;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willard Jr. 6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased June 4, 1923
(Month) (Day) (Year)

Immediate cause of death Ch. Valvular disease Duration 12 yr.

8. AGE: Years 23 Months 5 Days 10 If less than one day _____ hr. _____ min.

Due to Rheumatic fever.
Due to Mitral Stenosis -

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

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

10. Usual occupation Housewife

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER
12. Name Jack Turner
13. Birthplace Metropolis Ill 1
(City, town, or county) (State or foreign country)
14. Maiden name Edna Fisher
15. Birthplace Metropolis Ill 1
(City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) Burial (b) Date thereof 11-16-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston Mo

18. (a) Signature of funeral director Welch Funeral Home
(b) Address Sikeston Mo

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

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

23. Signature Chas. J. Meccis (M. D. or _____)
Address Sikeston Date signed 12 Nov 46

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

MIN
12-12-46

RECEIVED

District Health Office No. 2,

District File Number 1246-1442

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 St. Keaton 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.

Registration District No. 232

Primary Registration District No. 307K

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

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Liketon
(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

June J. Westmoreland

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

7. Birth date of deceased June (Month) 4 (Day) 1946 (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ Day _____ Year 1946 Hour _____ minute _____ M.

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

Duration

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 place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-43212