

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 11 1947

Registration District No. 239

Primary Registration District No. 5825

Registrar's No. 85

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Parma (Comotwp)

(c) Name of hospital or institution: None

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Parma (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. 1 years

3. (a) PRINT FULL NAME MINNIE-SEBASTIAN

3. (b) If veteran, name war ✓

3. (c) Social Security No. None

4. Sex F 1 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Aug 31 1865 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 year 1947 hour 12 minute 45 A. M.

21. I hereby certify that I attended the deceased from Mar 1 1947 to Jan 26 1947 and that I last saw her alive on Jan 20 1947 and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 4 Days 25 If less than one day hr. min.

9. Birthplace State of Michigan (City, town, or county) (State or foreign country)

10. Usual occupation House Wif

Immediate cause of death Cardiac decomp

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

MOTHER FATHER { 12. Name Unknown 7

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

14. Maiden name Unknown

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

PHYSICIAN

Major findings: Of operations 950

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. Birthplace Unknown (City, town, or county) (State or foreign country)

18. (a) Informant's own signature Mrs J. H. Babrey

(b) Address Parma, Mo

17. (a) Medical (b) Date thereof Jan 27-47 (Month) (Day) (Year)

(c) Place of burial or cremation Malden Mo

18. (a) Signature of funeral director Wattens Funeral Service

(b) Address Parma, Mo

19. (a) 1/27/47 (Date received local registrar) (b) Dr. Brown (Registrar's signature)

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 _____

28. Signature Dr. Brown (M. D. or other)

Address Parma Date signed 1/27/47

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Office No. 2,

District File Number 247-177

Date Filed 2-7-47

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 Lynne Steele

Licensed Embalmer No. 7476

P. O. Address Nexter M.

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, above space should be left blank.