

No. 2
5-43
5-17-39
X38671

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1987

State File No. _____

FILED JAN 27 1947

Registration District No. 270

Primary Registration District No. 5909

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Missouri
Caruthersville

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 1, Box 204
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 year years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 100

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

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elenora Holloway

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

4. Sex Female 5. Color or race Negro

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

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

7. Birth date of deceased January 4, 1885
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11
year 1947 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from
Jan. 8 - 1947 to Jan. 11 - 1947
that I last saw her alive on Jan. 8 - 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
62 0 7 hr. min.

Immediate cause of death Influenza Duration 1 WEEK

Due to _____

Due to _____

9. Birthplace: (Unknown) Louisiana
(City, town, or county) (State or foreign country)

10. Usual occupation: Housekeeper

Other conditions (Include pregnancy within 3 months of death)

Major findings: 3 3/10

11. Industry or business _____

MOTHER FATHER { 12. Name Joe Pretty

{ 13. Birthplace Unknown _____ 9

{ 14. Maiden name Angeline Key (City, town, or county) (State or foreign country)

{ 15. Birthplace Unknown _____ 9
(City, town, or county) (State or foreign country)

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ida Hubbard

(b) Address R. 1, Box 204, Caruthersville, Mo.

17. (a) Removal (b) Date thereof Jan. 11, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Commerce, Missouri

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? _____

18. (a) Signature of funeral director F. J. Sparks
Cape Girardeau, Missouri

(b) Address _____

19. (a) _____ (b) Jessie B. Wilks
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

Means of injury 0

23. Signature J. R. Union (M. D. or other) _____
Address Caruthersville, Mo. Date signed 1-11-47

247

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

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..... *Frank Sparks*

Licensed Embalmer No. *3455*

P. O. Address. *Cape Girardeau* >

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. 270

Primary Registration District No. 5909

Registrar's No. _____

1. PLACE OF DEATH: Premiscott Rural

(a) County _____

(b) City or town _____
(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 Eleanor Holloway

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race B

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Jan (Month) 1947 (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) James B. Wilkes (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 1947 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 _____

Due to _____

Other conditions: _____ (include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-1987