

No. 2
8-43
5-17-30
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10110

State File No. _____

FILED APR 11 1947

Registration District No. 247

Primary Registration District No. 5830

Registrar's No. 29

1. PLACE OF DEATH:

(a) County New Madrid-Rural

(b) City or town 2 1/2 mi. Cavalon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 2 or 2 yrs
years, months or days

3. (a) PRINT FULL NAME Albert Laster

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

4. Sex male 2 | 5. Color or race colored | 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased: unknown
(Month) (Day) (Year)

8. AGE: Years 53 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Morden Miss. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Common labor

11. Industry or business _____

12. Name _____

13. Birthplace _____ 9 6
(City, town, or county) (State or foreign country)

14. Maiden name _____ 9 6

15. Birthplace _____ 9 6
(City, town, or county) (State or foreign country)

16. (a) Informant E. W. Laster

(b) Address Mathews Route 3 box 235

17. (a) Burial (b) Date thereof march 30 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) 4-5-47 (b) Thomas M. Sheeter
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid

(c) City or town 2 1/2 mi. y Cavalon
(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 March day 29
year 1947 hour 6 minute 55 A. M.

21. I hereby certify that I attended the deceased from 3-28 1947 to 3-29 1947
that I last saw him alive on 3-28-47 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Due to _____

Due to _____

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

Major findings: Of operations § 37

Of autopsy _____

Duration _____

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 _____ 2

23. Signature J. H. Gulbenko (M. D. or other) M.D.
Address Raymo Mo Date signed 4/30/47

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 447-523

Date Filed 7-9-47

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 242 Primary Registration District No. 5830

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Rural
(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 Albert Foster
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 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 55 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 _____
12. Name Unknown
13. Birthplace _____ (City, town or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ (City, town or county) (State or foreign country)

16. (a) Informant E.W. Foster
(b) Address Mathews MO RFD 233
17. (a) (Burial, cremation, or removal) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director Unknown
(b) Address Sebaston, Mo.
19. (a) _____ (b) _____ (Date received by 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 April 29
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)
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

MOTHER FATHER

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-10110