

No. 2
5-43
2-17-39
10-35671

FILED MAR 31 1947

Registration District No. _____

Primary Registration District No. 4375

Registrar's No. 199

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(If outside city or town limits, write "RURAL" and name of township)
(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 None
(Specify whether
In this community Life.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid
(c) City or town New Madrid
(If outside city or town limits, write "RURAL")
(d) Street No. City
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie Lee Miskell

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

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife Charles R. Miskell 6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased October 9, 1912
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 5 8 hr. min.

9. Birthplace Mias. Co. Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Joe Still

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

14. Maiden name Zura Ray

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

16. (a) Informant Charles R. Miskell

(b) Address New Madrid, Mo.

17. (a) Burial (b) Date thereof 3/9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richards Funeral Home

18. (a) Signature of funeral director Richards Und. Co.

(b) Address New Madrid, Mo.

19. (a) 3-12-47 (b) Richard Anderson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day Seventh
year 1947 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from March 6, 1947, to March 7, 1947;
that I last saw her alive on March 7, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

Due to _____

Due to _____

Other conditions Cholera 3/1/47
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
ADDITIONAL SUPPLEMENTAL INFO
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 O.B. Chandler (M. D. or other) _____

Address New Madrid Mo. Date signed 3/7/47

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

MOTHER FATHER

RECEIVED
District Health Office N
District File Number 347-8
Date Filed 3-28-8

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..... *P. G. Collins*.....
Licensed Embalmer No. 4346
P. O. Address New Madrid, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 199

Registration District No. 238

Primary Registration District No. 4354

1. PLACE OF DEATH:

(a) County new madrid
(b) City or town new madrid
(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 minnie S. moshell

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 _____

7. Birth date of deceased oct 9 1919
(Month) (Day) (Year)

8. AGE: Years 34 Months 5 Days _____ (If less than one day, min. 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local 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 7
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 _____

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 _____

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

SUPPLEMENTARY

S-10112