

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 28 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14350

State File No. _____

Registrar's No. 211

Misllies 238
Registration District No. _____

Primary Registration District No. 5823

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 2 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Matthews, Mo. R.F.D. 3
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret Stuart Thompson

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 W 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11 5 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 5 10 _____ hr. _____ min.

9. Birthplace Harrisburg Penna. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Retired

MOTHER FATHER
12. Name James Mesderfer
13. Birthplace Unknown Penna. 1
(City, town, or county) (State or foreign country)
14. Maiden name Mary Louise McKnight
15. Birthplace Unknown Penna. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mary Ella Britton
(b) Address Matthews, Mo. R.F.D. #3
17. (a) Burial (b) Date thereof 4/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston, Mo.

19. (a) 4-21-1947 (b) Helen Landreth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 15
year 1947 hour 12 minute 25 p.m.

21. I hereby certify that I attended the deceased from Feb 4 7
19 _____ to Death 19 _____
that I last saw her alive on 6 April 47
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardiac failure

Due to Arricular fibrillation

Due to fracture Hip - left

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL UNDERLINE the cause of death should be stated statistically.
INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 7a
(b) Date of occurrence Feb 27, 1947
(c) Where did injury occur? Matthews Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work? yes (Specify type of place) (e) Means of injury 0

23. Signature Charles J. Means (M. D. or other)
Address Sikeston Mo Date signed 15 Apr

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

RECEIVED

District Health Office No. 2

District File Number 442-63

Date Filed 4-25-47

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.....

Embalmer

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Hunter Albright

Licensed Embalmer No.....

4210

P. O. Address.....

5 Keston

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. 14350

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 Margaret Kampman

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 wid

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 Months Days (If less than one day) min.

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

10. Usual occupation

11. Industry or business

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 April year 1941 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 _____

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) Accident, fall,

(b) Date of occurrence _____

(c) Where did injury occur? Home, Matthews, New Madrid, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home, cause not known, struck floor

While at work? No (Specify type of place) (e) Means of injury home

23. Signature Chas. H. Means (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

