

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED SEP 9 1947

State File No.

Registration District No. 23

Primary Registration District No. 3010

Registrar's No. 269

16
14
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU

(b) City or town CAPE GIRARDEAU

(c) Name of hospital or institution:
611 NORTH ST. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE
(Specify whether years, months or days)

In this community 27 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County CAPE GIR.

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

(d) Street No. 611 NORTH ST
(If rural, give location)

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

3. (a) PRINT FULL NAME SELVIA V. KINDER

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

4. Sex FEMALE 5. Color or race WHITE

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

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

7. Birth date of deceased OCT. 22 - 1874
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept = day 2
year 1944 hour 7 minute 15 PM

21. I hereby certify that I attended the deceased from 8/11 1947 to 9/2 1947
that I last saw him alive on 9/2 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral
hemorrhage Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>10</u>	<u>10</u>	hr. _____ min. _____

Due to Myocardial

Due to WAS operated 1925 -
Cerebral Hemorrhage

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

Major findings:
Of operations _____

Of autopsy 40E

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

9. Birthplace GORDONVILLE Mo 6
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

MOTHER FATHER { 12. Name COLUMBUS BEAN

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

14. Maiden name MARY SMITH

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

16. (a) Informant GLEM G. KINDER

(b) Address CAPE GIRARDEAU

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

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director: Walters Ltd. 200

(b) Address Cape Girardeau Mo

19. (a) 9-3-47 (b) C. A. Summers
(Date received local registrar) (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 _____

23. Signature C. A. Summers (M. D. or other) _____
Address Cape Girardeau Mo Date signed 9/2/47

SEP 18 1947

RECEIVED

District Health Officer No. 4
District File Number 947-1161
Date Filed 9-8-47

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 Virgil W. Shelch

Licensed Embalmer No. 4102

P. O. Address Cape Girardeau - 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.