S. No. 2
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1947

Registration District No. 338

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33444

Primary Registration District No. 6148

Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Leora
(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 --
In this community Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard 103
(c) City or town Leora
(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

3. (a) PRINT FULL NAME SHABE E. BACON
3. (b) If veteran, name war --
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Tony Bacon
6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased Aug. (Month) 6, (Day) 1877 (Year)

8. AGE: Years 70 Months 1 Days 3 If less than one day hr. min.

9. Birthplace Cape Girardeau, (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James Lewis
13. Birthplace ----- (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name Nurcine Wills
15. Birthplace Cape County, (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Tony Bacon
(b) Address Leora, Missouri.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-47 (Month) (Day) (Year)
(c) Place: burial or cremation Dexter, Mo.
18. (a) Signature of funeral director Chiles Und. Co.
(b) Address Bloomfield, Mo.
19. (a) 10-3-47 (Date received local registrar) (b) Rose Webber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9th year 1947 hour 10:15 minute P. M.
21. I hereby certify that I attended the deceased from Aug. 1947, to Sept. 9 1947, that I last saw her alive on Sept. 8 1947 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Apoplexy
Due to Cerebral
Due to Hypertension
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature E. C. Masters (M. D. or other)
Address Advance, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

JUL 26 1948

JUN 3 1949

RECEIVED
District Health Office No. 2,
District File Number 1047-1293
Date Filed 10-6-47

JUN 23 1954

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, ~~[illegible]~~ & Lulu Cooper #3499, Registered Apprentice No. ....., working under my personal supervision.

Signed Ivan C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.