

FILED NOV 19 1947
238

Primary Registration District No. **#823**

Registration District No. _____

Registrar's No. **244**

1. PLACE OF DEATH:

(a) County *New Madrid*

(b) City or town *Grand - 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 *70 years*
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *New Madrid*

(c) City or town *Grand - New Madrid*
(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 *William Franklin Cauthorn*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *10* day *5*
year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from *June 9th* 1945 to *Oct 5th* 1947,
that I last saw him alive on *Oct 4th* 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death *Myocarditis (acute)*

Duration _____

4. Sex *Male*

5. Color or race *White*

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

6. (b) Name of husband or wife *May Jane Cauthorn*

6. (c) Age of husband or wife if alive *dead* years _____

7. Birth date of deceased *September - 24 - 1870*
(Month) (Day) (Year)

Due to *Mitral Regurgitation*
Bronchial Asthma

Due to _____

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

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

9. Birthplace *New Madrid Co - Missouri*
(City, town, or county) (State of foreign country)

10. Usual occupation *Farming*

11. Industry or business _____

12. Name *Crawford Cauthorn*

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

14. Maiden name *Amanda Harris*

15. Birthplace *New Madrid Co, Missouri*
(City, town, or county) (State of foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

16. (a) Informant *Leonard Cauthorn*

(b) Address *New Madrid Mo*

17. (a) *Burial* (b) Date thereof *10-6-47*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Evergreen Cemetery - New Madrid*

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? _____

18. (a) Signature of funeral director *A. L. ...*

(b) Address *Portsmouth Mo*

19. (a) *10-19-47* (b) *Nelson Lane Jones*
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature *O.B. Chandler* (M. D. or other) *MD*
Address *New Madrid Mo* Date signed *10/8/47*

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1147-148

Date Filed 11-29-47

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.