

S. No. 2
4-147
5-17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41000**

National Office of Vital Statistics
FILED DEC 31 1947
Registration District No. **3007**

Primary Registration District No. **3007**

Registrar's No. **437**

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

1. PLACE OF DEATH:

(a) County Butter

(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 127 N. 8 ST
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lizzie Cardwell

3. (b) If veteran, name war: _____

3. (c) Social Security No. _____

4. Sex Fem 3 5. Color or race Negro

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

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: Aug 10, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>About 72</u>	<u>4</u>	<u>8</u>		hr. min.

9. Birthplace: Walnut Ridge, Ark
(City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business: _____

MOTHER FATHER

12. Name: Unknown 9

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: Abe Cardwell

(b) Address: 2718 Mill St - St. Louis Mo

17. (a) Burial (b) Date thereof: 12-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: City - Poplar Bluff, Mo

18. (a) Signature of funeral director: Frank Cotwell

(b) Address: Poplar Bluff, Mo

19. (a) 12/20/47 (b) R. Brunette
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butter

(c) City or town Poplar Bluff
(If outside city or town limits, write "RURAL")

(d) Street No. 127 N. 8 ST
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18
year 1947 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from Sept 17, 1947 to Dec 18, 1947
that I last saw her alive on 10 Dec 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Decompensation 3 Mos.

Due to arteriosclerosis

Due to Repetitive Heart Pain ?

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

PHYSICIAN

Major findings: None

Of operations: None

Of autopsy: None

Underline the cause of 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: [Signature] M.D. or other _____

Address: 32 Oak Poplar Bluff Mo

12-20-47

MAR 30 1948

MAR 30 1948

RECEIVED

District Health Office No. 2,

District File Number 247-1642

Date Filed 12-29-47

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

John M. Davies
working under my personal supervision.

Registered Apprentice No. 487

Signed [Signature]

Licensed Embalmer No. 2964

P. O. Address Poplar Bluff 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.

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 437

1. PLACE OF DEATH:

(a) County Buller
(b) City or town Poplar Bluff
(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 Lizzie Cordwell

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

4. Sex F 5. Color or race B
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Aug 10
(Month) (Day) (Year)

8. AGE: Years 72 Months _____ Days _____
If less than one day _____ hr. _____ min.

9. Birthplace AR
(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) 12/20/47 (b) R. H. Minette
(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 Dec Day 18
year 1947 hour _____ minute _____ M.

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

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

4/1000