

LED JAN 6 1947

Registration District No. **23**Primary Registration District No. **3010**Registrar's No. **393**

1. PLACE OF DEATH:

(a) County **CAPE GIRARDEAU**
 (b) City or town **CAPE GIRARDEAU**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **ST. FRANCIS HOSPITAL**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 DAYS**
 In this community **10 YEARS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **CAPE GIR. II**
 (c) City or town **CAPE GIRARDEAU**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **442 No. FREDERICK ST.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **✓**

3. (a) PRINT FULL NAME **ANNIE H. McPHEETERS**

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 **JAN - 13 - 1861**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
86 11 14 hr. min.9. Birthplace **NEW MADRID Co. Mo.**
(City, town, or county) (State or foreign country)10. Usual occupation **HOUSE WORK**11. Industry or business **HOME**12. Name **ISAAC HUNTER**13. Birthplace **NEW MADRID Mo.**
(City, town, or county) (State or foreign country)14. Maiden name **ELINORE MAULSBY**15. Birthplace **LOUISVILLE KY.**
(City, town, or county) (State or foreign country)16. (a) Informant **CHESTER McPHEETERS**(b) Address **WEBSTER GROVES, Mo.**17. (a) **BURIAL** (b) Date thereof **12-29-47**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation: **LORIMIER GEM.**18. (a) Signature of funeral director **Walthers Funeral Home**(b) Address **Cape Girardeau Mo.**19. (a) **12-31-47** (b) **C. G. Summers**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **27**
year **1947** hour **9** minute **45 P.M.**21. I hereby certify that I attended the deceased from **Dec 1**
2 _____, 1947, to **Dec 26**, 1947,
that I last saw h **h** alive on **Dec 26**, 1947,
and that death occurred on the date and hour stated above.Immediate cause of death **Uremia** Duration **3 day**Due to **Chr. nephritis** 10 yrs

Due to _____

Other conditions **Fractured Rt hip** 7 day
(Include pregnancy within 3 months of death)Major findings:
Of operations _____
Of autopsy _____
186A
18
ADDITIONAL SUPPLEMENTARY INFORMATION
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 **115**(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 **0**23. Signature **H. G. Ruff** (M. D. or other) **MD**
Address **Jackson** Date signed **12-30-47**

RECEIVED

Public Health Officer No. 4
District File Number 148-5
Date Filed 1-5-48

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

Richard O. Laine

Registered Apprentice No. 502

working under my personal supervision.

Signed

Virgil H. Welch

Licensed Embalmer No. 4102

P. O. Address

Cape Girardeau

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. *Jan*
Registrar's No. _____

Registration District No. *53*

Primary Registration District No. *3010*

1. PLACE OF DEATH:

(a) County *Cape Girardeau*
(b) City or town *Cape Girardeau*
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Cape Gir*
(c) City or town *Cape Gir*
(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

Annice H. McPheeters

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 *Jan 13 1913*
(Month) (Day) (Year)

8. AGE: Years *86* Months _____ Days _____ If less than one day hr. _____ min. _____

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* Day *23* Year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) *186A*

Major findings: Of operations _____ *186A*

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) *accident* ✓

(b) Date of occurrence *Dec 23 1947*

(c) Where did injury occur? *Jackson Cape Gir MO*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *convalescent home*

While at work? *no* (Specify type of place) (e) Means of injury *Fell on floor*

23. Signature *T. E. Puff* (M. D. or other) *MO*

Address *Jackson MO* Date signed *1-14-48*

SUPPLEMENTARY

MOTHER, FATHER

41092