

S. No. 2
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED JAN 22, 1948
 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 3019

Registrar's No. 10

1. PLACE OF DEATH:
 (a) County Dunklin
 (b) City or town Kennett
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Presnell Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 3 Days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Dunklin
 (c) City or town Kennett
(If outside city or town limits, write "RURAL")
 (d) Street No. Presnell Hospital
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Brenda Faye House
 3. (b) If veteran, name war X 3. (c) Social Security No. X
 4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced X
 6. (b) Name of husband or wife Calvin X 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased January 7, 1948
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 10th
 year 1948 hour 1:30 minute 3:20 P.M.
 21. I hereby certify that I attended the deceased from Jan. 10, 1948 to Jan. 10, 1948
 that I last saw her alive on Jan. 10, 1948
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>3</u>	_____ hr. _____ min.

Immediate cause of death Coronary heart disease
 Due to _____
 Due to _____

9. Birthplace Kennett, Missouri
(City, town, or county) (State or foreign country)
 10. Usual occupation X
 11. Industry or business X
 12. Name Calvin House
 13. Birthplace Portageville, Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Helen Medlin
 15. Birthplace Blytheville, Arkansas
(City, town, or county) (State or foreign country)

Other conditions None
(Include pregnancy within 3 months of death)
 Major findings: Of operations None
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 16. (a) Informant Calvin House
 (b) Address Caruthersville, Mo.
 17. (a) Removal (b) Date thereof 1/10/48
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Caruthersville, Mo.
 18. (a) Signature of funeral director H.S. Smith Funeral Home
 (b) Address Caruthersville, Mo.
 19. (a) 1-14-48 (b) Calvin House
(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?
(Specify type of place) (e) Means of injury
 23. Signature E. H. Nelson (M. D. or other) MD
 Address Caruthersville, Mo. Date signed 1-10-48

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

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RECEIVED

District Health Office No. 2

District File Number 148-118

Date Filed 1-19-48

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.....

Body was not Embalmed

..... Registered Apprentice No.....

working under my personal supervision.

Signed..... *James A. Osburn*.....

Licensed Embalmer No. 4185

P. O. Address Barthersville, 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.