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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9528

State File No. _____

Registrar's No. 276

FILED APR 9 1948

Registration District No. 238

Primary Registration District No. 4355

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

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: No.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No. (Specify whether years, months or days) 7 years.

3. (a) PRINT FULL NAME Jim Lacey

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

4. Sex M 2. Color or race Colored

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct. - 1981
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
about 67 hr. _____ min. _____

9. Birthplace Jackson Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Farm Labor

11. Industry or business _____

12. Name unk

13. Birthplace unk unk
(City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace unk unk
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Smith

(b) Address New Madrid, Mo.

17. (a) Burial (b) Date thereof 3/9-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sand hill

18. (a) Signature of funeral director Richard L. ...

(b) Address New Madrid, Mo.

19. (a) 3-15-48 (b) Nelson Love Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town _____
(If outside city or town limits, write "RURAL") 72

(d) Street No. _____
(If rural, give location) 40

(e) Citizen of foreign country? _____ (Yes or No) ?
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1948 hour 2:00 minute a. M.

21. I hereby certify that I attended the deceased from Mar 2nd, 1948, to March 8, 1948,
that I last saw him alive on Mar 2nd, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

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 B. Chandler (M. D. or other) MD
Address New Madrid Mo Date signed 3/15/48

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED

District Health Office No. 2

District File Number 448-253

Date Filed 4-5-48

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.....

W. L. Emanuel 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *April*
Registrar's No. *276*

Registration District No. *238* Primary Registration District No. *4355*

1. PLACE OF DEATH:

(a) County *New Madrid*

(b) City or town *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 _____
years, months or days

3. (a) PRINT FULL NAME *Jim Lacey*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *m*

5. Color or race *B*

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *Oct*
(Month) (Day) (Year)

8. AGE: *all 67*
Years Months Days If less than one day
hr. _____ min. _____

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 *May* year *1948* 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 *Bronchopneumonia*

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations *107*

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 *O.B. Chandler* (M. D. or other) *MD*

Address *New Madrid Mo* Date signed *4/2/48*

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

SUPPLEMENTARY

S-9528

11 - 1954

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O B Church