

No. 2
2-437
17-39
X33697

FILED APR 6 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9618

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 27

1. PLACE OF DEATH:
 (a) County Pemiscot
 (b) City or town Caruthersville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
West ave 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 26 years. years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pemiscot
 (c) City or town Caruthersville 74
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1309 West ave 1
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 2
 If yes, name country _____ 0

3. (a) PRINT FULL NAME Sarah Janett
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 24
 year 1948 hour 10 minute 15 M.
 21. I hereby certify that I attended the deceased from 3/12/48 1948 to 3/24/48 1948
 that I last saw h. er alive on 3/24/48 1948
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death _____ Duration
Coronary sclerosis. ✓
 Due to _____
 Due to _____
 Other conditions _____ (include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

7. Birth date of deceased May 10 1884
 (Month) (Day) (Year)
 8. AGE: Years 63 Months 10 Days 14 If less than one day _____ hr. _____ min.
 9. Birthplace Murphy Tenn (City, town, or county) (State or foreign country)
 10. Usual occupation Home work

11. Industry or business _____
 12. Name unknown 9
 13. Birthplace _____ (City, town, or county) (State or foreign country)
 14. Maiden name _____ 4
 15. Birthplace _____ (City, town, or county) (State or foreign country)

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 A. W. Weeks (M. D. or other)
 Address Caruthersville Date signed 3/26

16. (a) Informant Mrs. Lela Helms
 (b) Address Caruthersville Mo.
 17. (a) Burial (b) Date thereof 3-24-1948
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Morgan Ridge
 18. (a) Signature of funeral director Lafayette Ind. Co.
 (b) Address Caruthersville Mo.
 19. (a) 3-31-48 (b) Jessie G. Weeks
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline name to indicate death should be charged statistically.
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

4-48-111

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.....

Boyd B. Willis

Registered Apprentice No. *19*

working under my personal supervision.

Signed.....

Holl C. Deane

Licensed Embalmer No. *3941*

P. O. Address: *Conthamville*

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.

No. 25
45
1 X 43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 27

Registration District No. 270 Primary Registration District No. 3050

1. PLACE OF DEATH:
(a) County Pemissot
(b) City or town Caruthersville
(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 Loach Janet
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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

8. AGE: Years 63 Months _____ Day _____ If less than one day hr. _____ min. _____

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

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

(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 Day 10 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to arteriosclerosis
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 97

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) (c) Means of injury
23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

S-9618

10002

10003

10004

10005