DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 18 1948

Registration District No. 53

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15635

Primary Registration District No. 3010

Registrar's No. 153

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: SO. E. MO. HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 WEEKS (Specify whether years, months or days)

In this community 45 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County CAPE GIR. 16

(c) City or town CAPE GIRARDEAU. 1
(If outside city or town limits, write "RURAL")

(d) Street No. 426 No. FREDERICK 4
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country ✓

3. (a) PRINT FULL NAME OTILLIE H. IRION

3. (b) If veteran, name war

3. (c) Social Security No. 0

4. Sex FEMALE

5. Color or race WHITE

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 JAN. (Month) 2 (Day) - 1890 (Year)

8. AGE: Years 57 | Months 11 | Days 9 | If less than one day hr. min.

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

10. Usual occupation CLERK

11. Industry or business CLOTHING STORE

FATHER
12. Name CHRISTIAN F. IRION
13. Birthplace INDIA (City, town, or county) 7 (State or foreign country)

MOTHER
14. Maiden name META MASHMEYER
15. Birthplace ST. LOUIS. (City, town, or county) MO (State or foreign country)

16. (a) Informant MRS. H. L. WATKINS

(b) Address CAPE GIRARDEAU

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY-14-48 (Month) (Day) (Year)

(c) Place: burial or cremation FAIRMOUNT CEM.

18. (a) Signature of funeral director Walthers Funeral Home

(b) Address Cape Girardeau, Mo

19. (a) 5-14-48 (Date received local registrar) (b) C. C. Summers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1948 hour 11:58 minute P M.

21. I hereby certify that I attended the deceased from Nov. 28, 1947, to May 11, 1948; that I last saw her alive on May 11, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Abdominal Carcinoma - Tosis. — Duration ?

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 55 K

Major findings: Of operations Inoperable carcinoma

Of autopsy

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

While at work? (e) Means of injury

23. Signature Charles F. Wilson (M. D. or other) M.D.

Address 727 Broadway Cape Girardeau, Mo. Date signed 5-13-48

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 548-641

Date Filed 5-17-48

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. Laird, Registered Apprentice No. 502, working under my personal supervision.

Signed Virgil H. Welch

Licensed Embalmer No. #102

P. O. Address Cape Girardeau - 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.

No. 2B
I—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 153

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 (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

3. (a) PRINT FULL NAME Otillie H. Irion

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 2 (Day) 1 (Year)

8. AGE: Years 57 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May 11
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Primary site of malignancy was impossible to locate at operation

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations C.W

Of autopsy 55K

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-15635