No. 2
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 29 1948

Registration District No. 217

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5786

State File No. 20180

Registrar's No. 5-1

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston-Rural-Ohio Twn.
(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 10 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 67

(c) City or town Charleston-Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Brewer's Lake 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Alice LaVerne Cade

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 Infant 0

6. (b) Name of husband or wife

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

7. Birth date of deceased May 30, 1948
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	hr 20 min.

9. Birthplace Charleston, R.3, Mo. 6
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Jacob Henry Cade /
13. Birthplace Green County, Ark.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Zelma Irene Presson
15. Birthplace New Madrid Co., Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob Cade
(b) Address R. 3, Charleston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-48 (Month) (Day) (Year)

(c) Place: burial or cremation Dogwood

18. (a) Signature of funeral director Travis Shelby
(b) Address East Prairie Mo.

19. (a) 6-23-48 (Date received local registrar) (b) Mrs. John Bondurant (Registrar's signature) 191

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1948 hour 4:00 minute A M.

21. I hereby certify that I attended the deceased from birth, 3:40 A.M.
May 30, 1948, to 5/30/48, 19..;
that I last saw her alive on 5/30/48, 19..;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hydrocephalus-Spina Bifida	
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? 2
(Specify type of place)

While at work? (e) Means of injury

23. Signature T. P. Fenton (M. D. or other) DO

Address Wyatt, Mo. Date signed 5/30/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 68-820
Date Filed 6-28-68

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 not embalmed, Registered Apprentice No. working under my personal supervision.

Signed Travis Shelby

Licensed Embalmer No. 272

P. O. Address East Prairie, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.