

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

No. 2
2-43
17-39
X-35697

FILED DEC 15 1948

State File No.

Registration District No. 238

Primary Registration District No. 5823

Registrar's No. 310

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town New Madrid Rural
(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
In this community About 10 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural 6 Miles N.E. of N.M.
(If outside city or town limits, write "RURAL")

(d) Street No. - (If rural, give location) 0

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

3. (a) PRINT FULL NAME Monroe Eldon Starr

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29
year 1948 hour 4:00 minute P. M.

4. Sex MO 5. Color or race W

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

(b) Name of husband or wife Emile Starr 6. (c) Age of husband or wife if alive -26- years

7. Birth date of deceased Dec -26- 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 13, 1948, to Oct 29, 1948
that I last saw him alive on Oct 27, 1948
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>10</u>	<u>3</u>	hr. min.

Immediate cause of death Pneumonia Duration _____

Due to _____

Due to _____

9. Birthplace unk. (City, town, or county) Ill. 1 (State or foreign country)

10. Usual occupation Retired

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

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

MOTHER FATHER {

12. Name unk. (a)

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

14. Maiden name unk.

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

16. (a) Informant Samuel Starr
(b) Address Matthews Rt 1

17. (a) Burial (b) Date thereof Oct 31 - 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maunda

18. (a) Signature of funeral director Richard Ford Co.
(b) Address New Madrid, Mo.

19. (a) 12-3-48 (b) Helene Louise Jones
(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature O.B. Chandler (M. D. or other) MD
Address New Madrid Date signed 12/2/48

RECEIVED

District Health Office No. 2,

District File Number 1248-1657

Date Filed 12-13-48

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed L. B. Hedges

Licensed Embalmer No. 3803

P. O. Address New Madrid

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

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

Registration District No. 239 Primary Registration District No. 5823

1. PLACE OF DEATH:
 (a) County New Madrid
 (b) City or town Reed
 (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 m. a. Star
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

7. Birth date of deceased See 26
 (Month) (Day) (Year)
 8. AGE: Years 88 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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. (c) _____ (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 _____ Day _____
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 Bronchopneumonia
 Due to Coronary
 Other conditions (include pregnancy within 3 months of death) _____

Major findings:
 Of operations _____
 Of autopsy _____

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 _____ (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-37464