

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10725**

FILED MAR 23 1953

BIRTH NO. _____ REG. DIST. NO. **240** PRIMARY REG. DIST. NO. **4358** Registrar's No. **7**

720
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lilbourn	c. LENGTH OF STAY (in this place) 13trs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lilbourn 0720	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) a. (First) Mattie	b. (Middle) L.	c. (Last) Allred	4. DATE OF DEATH (Month) (Day) (Year) March 9 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH June 22 1876	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR (Months) 8	11. UNDER 24 HRS. (Days) 17
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Cherokee, Alabama	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME George Rayburn	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME George Allred-St. Louis, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 8, 1953**, to **Feb 9, 1953**, that I last saw the deceased alive on **Feb 8, 1953**, and that death occurred at **8:40a.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. E. Jones M.D. (Degree or title)	23b. ADDRESS Lilbourn Mo	23c. DATE SIGNED Feb 11 53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-10-53	24c. NAME OF CEMETERY OR CREMATORY Mounds Park	24d. LOCATION (City, town, or county) (State) Lilbourn, Mo.
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DATE REC'D BY LOCAL REG. 3-14-53	REGISTRAR'S SIGNATURE H. L. Ponder Deputy	25. FUNERAL DIRECTOR'S SIGNATURE Ponder Funeral Home-Lilbourn, Mo.	ADDRESS
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Dr. Jones

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Horner L. Ponder*

Licensed Embalmer No. *3367*

P. O. Address *Lilbourn, 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.