

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

3660  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Pemiscot Registration District No. 656  
 (b) Township Holland Primary Registration District No. 628 Registered No. \_\_\_\_\_  
 (c) City Holland (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 25 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

Bessie Weeks 200  
 (a) Residence, No. Holland, Mo. Pemiscot St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 2nd 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robie Weeks

22. I HEREBY CERTIFY, That I attended deceased from Oct 21 1937, to Feb 2 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4/1.1912.

I last saw her alive on Jan 3 1938. Death is said to have occurred on the date stated above, at 4:30 m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
25 10 3

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeper  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Pulmonary Tuberculosis Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Holland (STATE OR COUNTRY) Mo.

Other contributory causes of importance: 22

FATHER 13. NAME Bennie Lester  
 14. BIRTHPLACE (CITY OR TOWN) Huffman (STATE OR COUNTRY) Ark.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER 15. MAIDEN NAME Martha Lester  
 16. BIRTHPLACE (CITY OR TOWN) Elchorn (STATE OR COUNTRY) Tenn

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) Robie Weeks  
Holland, Mo.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Zion Cem DATE 2/3. 1938

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) German Undt Co.  
Steele, Mo.

(Signed) P. E. Cooper, M. D.  
Coates, Mo. (Address)

20. FILED 2-12-38 Tom Bugner Local Registrar. 588

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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FEB 28 1933

BUREAU OF VITAL STATISTICS  
MO. STATE BOARD OF HEALTH

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by .....

..... L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed .....

Licensed Embalmer No. ....

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