

FORM NOV 1 0 1938

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

36361
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605
 (b) Township Cross Primary Registration District No. 4559 Registered No. _____
 (c) City _____ (d) Street No. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ella Sheffield
 (a) Residence, No. _____ 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

3. SEX F 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Arthur Sheffield
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 15, 1894
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 44 9 13
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Wife
 9. Industry or business in which work was done, as saw mill, bank, etc. Wife
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 28, 1938

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1938, to Oct 28, 1938.

I last saw her alive on Oct 28, 1938 Death is said to have occurred on the date stated above, at 9 P.M.

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

Cerebral hemorrhage Date of onset _____
8221
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis Clinical Was there an autopsy? No

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.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify Cerebral hemorrhage
 (Signed) Dr. W. J. Rust, M. D.
 (Address) Parma, Mo

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

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Arthur Sheffield
Parma Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Stones Chapel DATE 10-29, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Watkins 534
Dr. J. W. Rust

20. FILED 11/4, 1938 Dr. J. W. Rust
Local Registrar.

Every item of information should be carefully classified. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.