

REC'D SEP 20 1939

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

29866

Do not use this space.

## 1. PLACE OF DEATH

 (a) County Demers Registration District No. 651  
 (b) Township Caruthersville Primary Registration District No. 4388 Registered No. 88  
 (c) City Caruthersville (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
BERTHA MAY SCRIBNER  
 (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) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 6-1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
0 2 11

 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.   
 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 \_\_\_\_\_
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Caruthersville, Mo13. NAME Luther Scribner14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown15. MAIDEN NAME Corena Champion16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Burgadoo, Mo17. INFORMANT (ADDRESS) Luther Scribner18. BURIAL, CREMATION, OR REMOVAL PLACE Caruthersville, Mo DATE 8/19 3919. FUNERAL DIRECTOR (NAME) (ADDRESS) Fargo Ind. Co20. FILED Sept. 1, 1939 Elda Martin Local Registrar.21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 17-193922. I HEREBY CERTIFY, That I attended deceased from Aug. 16-1939, to Aug. 17-1939I last saw her alive on Aug. 16-1939. Death is said to have occurred on the date stated above, at 6:30 P.M.

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

Malnutrition

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? No

If so, specify \_\_\_\_\_

(Signed) J. R. Parson, M. D.(Address) Caruthersville, Mo.

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RECEIVED

District Health Officer No. 3

District File Number 939-52

Date Filed 9/6/39

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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29866  
Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 657  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4388 Registered No. 86  
 (c) City Caruthersville (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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 Bertha May Derisner

(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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
2 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 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

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-11, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

malnutrition Date of onset

This was a bottle baby and no cause of malnutrition was determined

Other contributory causes of importance:  
other than improper feeding.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 of injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.

(Address) Caruthersville

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

