

Registration District No. 651 Primary Registration District No. 4388 Registrar's No. 189

1. PLACE OF DEATH:

(a) County Pemiscot 2

(b) City or town Cauthersville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bushy St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 20 years years, months or days

3. (a) PRINT FULL NAME Malinda Yoda

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

4. Sex Female 5. Color or race B. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive ✓ years
(Day) (Year)

7. Birth date of deceased 8 28 1893
(Month) (Day) (Year)

8. AGE: Years 46 Months 3 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Wess Yoda

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

14. Maiden name Deborah Dyl

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

16. (a) Informant's own signature Malinda Yoda

(b) Address Cauthersville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date of burial 12 5 39
(Month) (Day) (Year)

(c) Place: burial or cremation St. Michaels Cemetery

18. (a) Signature of funeral director W. Smith

(b) Address Cauthersville Mo

19. (a) Dec. 29, 1939 (Date received local registrar) (b) Geda Martin (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot

(c) City or town Cauthersville
(If outside city or town limits, write "RURAL")

(d) Street No. Bushy ave. (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12, day 2
year 39 hour _____ minute 30 P.M.

21. I hereby certify that I attended the deceased from head, 1939, to Dec ✓, 1939
that I last saw her alive on Dec ✓, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 day

Due to _____

Due to gout

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 W. Cair (M. D. or other) _____
Address Cauthersville Mo Date signed 12/5/39

MARGIN RESERVED FOR BINDING

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

N. B.—Every item of information should be carefully supplied. 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.

REMOVED

District Health Officer No: 13,

District File Number 140-805

Date Filed 1/19/40

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 W. C. Dean

Licensed Embalmer No. 3941

P. O. Address Caruthersville, 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, above space should be left blank.