

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.

Registration District No. 290

Primary Registration District No. 5408

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town Senick Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13 - 1948
 year _____ hour _____ minute 8 A. M.
 21. I hereby certify that I attended the deceased from July 11-48
July 12, 1948, to _____, 19____,
 that I last saw her alive on July 12, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death: General Sepsis! Duration _____
 Due to local infection
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

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?
2 1 3
 While at work? _____ (Specify type of place)
 Means of injury _____
 23. Signature Robert E. Martin (M. D. or other) _____
 Address Senick Missouri Date signed 7-13-48

8. (a) PRINT FULL NAME ORVA EVELYN WATERS ^{2, 1, 66}

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife Oscar Rogers Waters 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased June 28 1913
 (Month) (Day) (Year)

8. AGE: Years 27 Months _____ Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation wife

11. Industry or business _____

12. Name Eliay Robert Noonan

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

14. Maiden name Mary Anna White

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

16. (a) Informant's own signature Oscar R. Waters

(b) Address Senick Mo. Rt. 1

17. (a) McDrew (b) Date thereof July 15 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McDrew

18. (a) Signature of funeral director Howard Underless

(b) Address Cardwell Mo.
 (c) Aug 2-1948 (d) A. D. McDaniel
 (Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 2

Dis. Act. File Number 840-1361

Date Filed 8/13/40

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. H. Howard

Licensed Embalmer No. 3959

P. O. Address Leaksville, Md.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 25-100

Registration District No. 290

Primary Registration District No. 2408

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Salem, P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mrs. Evelyn Waters

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
27 - 15 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER-FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 13
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia

Due to Local Infection

Due to Self Abortion & Shred of Sepsis

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____ 17.5 W

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (c) Method of injury _____

23. Signature Robert E. Martin (her) _____
Address Salem, Mo Date signed _____

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

SUPPLEMENTARY

