

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.

AUG 3 1940

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

25819
Do not use this space.

1. PLACE OF DEATH
 (a) County New Madrid Registration District No. 25
 (b) Township Bidean Primary Registration District No. 4033
 (c) City _____ (d) Street No. _____
 (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 Jonell Filer
 (a) Residence, No. Bidean Mo 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 2 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 10 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 6 22
 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. Infant
 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) Bidean 0
 FATHER 13. NAME Claud Filer 0
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sikeston 0
 MOTHER 15. MAIDEN NAME Nora Foister
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Morley
 17. INFORMANT (ADDRESS) Claud Filer
Bidean Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE July 3 1940
Sikeston, Mo.
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) 541
M. V. Murren
 20. FILED July 7 1940 M. V. Murren
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 2 1940
 22. I HEREBY CERTIFY, That I attended deceased from June 25 1940, to July 2 1940
 I last saw him alive on June 30 1940 Death is said to have occurred on the date stated above, at 2 A m.
 The principal cause of death and related causes of importance were as follows:
Pertussis
9
 Other contributory causes of importance:
Acute Ills Colitis
 Date of onset 6/7/40
 Date of death 6/21/40
 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 _____
 (Signed) John Paul Deane, M. D.
Malden Mo
 (Address)

RECEIVED

District Health Officer No. 2

District File Number 840-125

Date Filed 8/1/40

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.....

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.

No. 21-40
X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 25-819

Registration District No. 55

Primary Registration District No. 4033

Registrar's No. 32

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Sweden
(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 _____ years, months or days) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jonell Files

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W

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

7. Birth date of deceased Dec 10 1930
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

6 22 _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-25-40 (b) [Signature]
(Date received local registrar) (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.

20. DATE OF DEATH Month July day 2
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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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?
_____ (Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

