

SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29179

X21492

Registration District No. 1133 Primary Registration District No. 45-89 Registrar's No.

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town CANALOU
(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. 26 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert A. Flowers
3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex MALE 5. Color or race COL. 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 26 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>26</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Robert Flowers
13. Birthplace Liberly MISS
(City, town, or county) (State or foreign country)
14. Maiden name Alpertia
15. Birthplace Holly Spring MISS
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Flowers
(b) Address Canalou Mo

17. (a) Burial (b) Date thereof 8-22-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ives STON Mo

18. (a) Signature of funeral director John Albritton
(b) Address St. Ives St. Mo

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid
(c) City or town CANALOU RPH 3
(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 Aug day 22
year 1940 hour 8 minute AM
21. I hereby certify that I attended the deceased from Aug 21
1940 to Aug 27 1940
that I last saw her alive on Aug 27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Falor Pyemia

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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? 540 (Specify type of place)
(e) Means of injury _____

28. Signature Am. Jarno (M. D. or other) MD
Address Morehouse, Mo. Date signed 8-22-40

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

RECEIVED

District Health Officer No.

District File Number 840-14

Date Filed 9/10/4

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **29179**

Registration District No. **1133**

Primary Registration District No. **45-87**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **New Madrid**

(b) City or town **Canalou**
(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 _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **W. m**

(c) City or town **Canalou**
(If outside city or town limits write "RURAL")

(d) Street No. **P.R.#3**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Robert A. Flowers**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month **Aug** day **22** year **1940** hour _____ minute _____ M.

4. Sex **m**

5. Color or race **col**

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

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

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 _____

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

8. AGE: Years _____ Months _____ Days **26** If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **10-18-40** (b) **Jaw D Kochel**
(Date received local registrar) (Registrar's signature)

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 **S. M. Sarno** (M. D. or other) _____
Address **Morehouse mo** Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

