

SEP 25 1940

On Chap

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29315

Registration District No. _____

Primary Registration District No. 655

Registrar's No. 8872

1. PLACE OF DEATH:

(a) County Pemiscot
 (b) City or town Steele "Rural" Virginia
(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 41 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot
 (c) City or town Steele 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.

3. (a) PRINT FULL NAME Macie Cecil 240

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorce
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 6 11 1899
(Month) (Day) (Year)

8. AGE: Years 41 Months 1 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 { 12. Name John Flowers
 { 13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
 { 14. Maiden name Mattie Pullum
 { 15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Hattie Statler

(b) Address Steele, Missouri

17. (a) Burial (b) Date thereof 8-3-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion

18. (a) Signature of funeral director J. L. German

(b) Address Steele, Missouri

19. (a) 9/4/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2 nd.
 year 1940 hour 8 minute 15 A. M.
 21. I hereby certify that I attended the deceased from March 5
 1940 to Aug 2, 1940,
 that I last saw her alive on Aug 1, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Bright's Disease
 Duration _____

Due to Cardio-Renal failure

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? _____

23. Signature [Signature] (M. D. or other) 1
 Address Steele, Mo. Date signed _____

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

9-40-17

1322

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 William C Shelton

Licensed Embalmer No. 3929

P. O. Address Steele, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 29815

Registration District No. 65-5

Primary Registration District No. 3872

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Pemscot

(b) City or town Virginia (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

3. (a) PRINT FULL NAME Macie Cecil

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

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

8. AGE: Years 41 Months 1 Days 21 If less than one day _____ 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 _____ (State or foreign country)

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) _____ (b) _____ (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 Aug 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 Bright's disease

Due to Cardio-Renal failure

(acute)

Due to _____

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

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) (c) Means of injury _____

23. Signature J.R. Chapman (M. D. or other) _____

Address Stalle MO Date signed 10/25/40

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

