Kendig

No. 2
-10-39
7-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 18 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32652

Registration District No. 603 Primary Registration District No. 4357 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 Morehouse
(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 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid

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

(d) Street No. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME ELLEN BROWN

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 Married

6. (b) Name of husband ~~or wife~~ Earnest Brown

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

7. Birth date of deceased 1 (Month) 1 (Day) 1911 (Year)

8. AGE: Years 29 Months 6 Days 4 If less than one day hr. min.

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

10. Usual occupation House work

11. Industry or business

FATHER
12. Name Riley Mathis
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Earnest Brown
(b) Address Morehouse Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-40 (Month) (Day) (Year)
(c) Place: burial or cremation Essex Mo. Rural

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 5 year 1940 hour 7 minute P M.

21. I hereby certify that I attended the deceased from 7-5-40, 19 , to 7-5-40, 19 ; that I last saw her alive on 7-5-40, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Peripheral fever

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) Miscarriage 7 mo.

Major findings:
Of operations
Of autopsy

Duration 4/1/40

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? 536 (Specify type of place)
While at work (e) Means of injury

23. Signature H M Kendig (M. D. or other) 1
Address Date signed 9/22/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2,
District File Number 1040-15
Date Filed 10/10/40

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 John Allerton

Licensed Embalmer No. 2941

P. O. Address Sikeston M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. 2B
-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 326572

Registration District No. 603 Primary Registration District No. 4357 Registrar's No.

1. PLACE OF DEATH
(a) County New Madrid
(b) City or town Morehouse
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Ellen Brown
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 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 29 Months 6 Days 4 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) 12.3.1940 (Date received local registrar) (b) Mrs John Parrish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month day year hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
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? (Specify type of place) (e) Means of injury
23. Signature H. M. Kendig (M. D. or other)
Address Date signed

SUPPLEMENTARY