

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. 381

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Paplar Bleuff

(c) Name of hospital or institution: Paplar Bleuff Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 hrs (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County BUTLER

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

(d) Street No. 629 Lindsay St
(If rural, give location)

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

3. (a) PRINT FULL NAME PEGGY LOU CARTWRIGHT

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
year 1940 hour _____ minute _____ M.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov 4 1940
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 12, 1940, to Dec 14, 1940, that I last saw him alive on Dec 14, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Branchiopneumonia 5 days

8. AGE: Years _____ Months 1 Days 10 If less than one day hr. _____ min _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Stanley Cartwright

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

14. Maiden name Willa Belle Cartwright

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

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

Major findings: Of operations _____

Of autopsy none

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Stanley Cartwright

(b) Address 629 Lindsay St Paplar Bleuff Mo

17. (a) Burial (b) Date thereof Dec 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation city cem

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? _____

18. (a) Signature of funeral director W. H. Sutz

(b) Address Paplar Bleuff Mo

19. (a) 12/27/40 (b) W. H. Sutz
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____

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

23. Signature W. H. Sutz (M. D. or other) MD
Address Paplar Bleuff Mo Date signed 12-21-40

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

2
2
2

107W

[Faint handwritten notes]

[Faint handwritten notes]

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41953

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. 381

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

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Peggy Lou Cartwright

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 8

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 Months Days If less than one day
1 10 hr. min.

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) 2/11/41 (b) Kate Lutz (Date received by 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14 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 Broncho pneumonia

Due to Respiratory infection
Due to non specific r.m.s.

Other conditions..... (Include pregnancy within 3 months of death) 1072

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?.....

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

23. Signature [Signature] (M. D. or other)
Address Poplar Bluff, Mo Date signed 2-11-41

SUPPLEMENTAL COPY

