

No. 2  
4-13-40  
-17-39  
K23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11476

Registration District No. 603 Primary Registration District No. 4354 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County New Madrid  
(b) City or town Hillbourn P.I.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Corona Hosp  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County New Madrid  
(c) City or town Hillbourn P.I.  
(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 Linda Fay Cecil  
(b) If veteran, name war 5 (c) Social Security No. 5

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar day 11  
year 1941 hour 2 minute a.m.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased March 10, 1941  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 10  
1941 to Mar 11, 1941  
that I last saw her alive on Mar 10, 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
\_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Blue Baby  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

12. Name Bessie Cecil  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Ethel Palmer  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

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?  
524 (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant Bessie Cecil  
(b) Address Hillbourn Mo. P.I.  
17. (a) Burial (b) Date thereof Mar. 11, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Malden Cem.

23. Signature D. Scott Kuestel (M. D. or other) MD  
Address Parma Mo. Date signed 3/11/41

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) 4-41 (b) D. Scott Kuestel  
(Date received local registrar) (Registrar's signature)

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

2  
0  
0

RECEIVED

District Health Officer No. 2

District File Number 441-480

Date Filed 4/11/41

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**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.**