

Reg. District No. 89

Primary Registration District No. 3007

Registrar's No. 333

## 1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Poplar Bluff  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Poplar Bluff Hospital  
 (If not to hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 weeks  
 In this community 2 weeks (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Ellen Pyles

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 married  
 6. (b) Name of husband or wife Ervin Pyles 6. (c) Age of husband or wife if alive 50 50 years  
 7. Birth date of deceased August 12 1896  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 0 11 hr. min.

9. Birthplace Maynard Arkansas  
 (City, town, or county) (State or foreign country)10. Usual occupation Housewife11. Industry or business self

MOTHER FATHER  
 12. Name Fred Gould  
 13. Birthplace Ohio (State or foreign country)  
 14. Maiden name Suzy Oldford (City, town, or county) (State or foreign country)  
 15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ervin Pyles(b) Address Maynard Arkansas17. (a) Removal (b) Date thereof 8-24-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Corning Arkansas18. (a) Signature of funeral director Trby Undertakers(b) Address Corning Arkansas19. (a) 8-30-41 (b) (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County 912  
 (c) City or town Maynard  
 (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 August day 23  
 year 1941 hour 10:00 minute 30 AM.21. I hereby certify that I attended the deceased from Aug 18, 1941, to Aug 23, 1941;  
 that I last saw h alive on \_\_\_\_\_, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration 1 day  
 Due to hypertension  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 12710

Major findings: large gall stones  
 Of operations gallbladder  
 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) acc  
 (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 Wm. H. H. H. (M. D. or other) \_\_\_\_\_  
 Address Poplar Bluff Mo Date signed 8-28-41

RECEIVED

District Health Office No. 2,

District File Number 941-1203

Date Filed 9/4/41

DEC 12 1957

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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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27890

Registration District No. 89

Primary Registration District No. 3007

Registrar's No. 333

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

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Poplar Bluff  
(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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ellen Pyles

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

4. Sex F 5. Color or race H 6. (a) Single, widowed, married, divorced in

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 \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8-30-41 (b) Belle Kinne  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 23 Year 1941 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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)

(b) 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

