

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

2  
43  
39  
37823

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 114

1. PLACE OF DEATH:

(a) County CAPE-GIRARDEAU

(b) City or town CAPE-GIRARDEAU  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
SOUTH EAST MISSOURI  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)

In this community 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ballinger

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

(d) Street No. near Patton mo.  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELLA-MAY-CRITES

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 494-03-287

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

6. (b) Name of husband or wife FEID-CRITES 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased December 11 1896  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

<u>47</u>	<u>3</u>	<u>14</u>	hr. min.
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9. Birthplace Ballinger Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

12. Name William COOK

13. Birthplace Ballinger Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Sean M. Brothers

15. Birthplace Ballinger Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Crites

(b) Address Sedgewickville mo

17. (a) Burial (b) Date thereof 3-28-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Port Oak Chapel

18. (a) Signature of funeral director Wilson, Stahli-Seebaugh

(b) Address Jackman mo

19. (a) 3-27-44 (b) F. H. Phelps  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 25  
year 1944 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from 3/20 1944 to 3/26 1944  
that I last saw her alive on 3/25 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Paronychia Duration \_\_\_\_\_

Due to Myocarditis

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 [Signature] (M. D. or other) \_\_\_\_\_

Address Port Oar mo Date signed 3/27/44

101K

RECEIVED

District Health Officer No. 4

District File Number 44-3673

Date Filed 4-7-44

APR 8 1944

JUN 16 1944

MAY 2 1944

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson W

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.