No. 2
5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 20 1944

Registration District No. 7

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14228

Primary Registration District No. 2007

Registrar's No. 107

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: 40 Days (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Carter
(c) City or town: Ellsinore
(If outside city or town limits, write "RURAL")
(d) Street No.: 0
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country: /

3. (a) PRINT FULL NAME: Mary C. Ambrose
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: Widow
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Mar (Month) 30 (Day) 1880 (Year)

8. AGE: Years 64 | Months 0 | Days 0 | If less than one day: hr. min.

9. Birthplace: Wayne Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Housekeeper
11. Industry or business:
12. Name (Father): Unknown
13. Birthplace (Father): " (City, town, or county) 9 (State or foreign country)
14. Maiden name (Mother): Unknown
15. Birthplace (Mother): " (City, town, or county) 9 (State or foreign country)
16. (a) Informant: Mrs Myrtle Foster
(b) Address: Poplar Bluff
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-2-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Chapel Hill
18. (a) Signature of funeral director: Phil A. Funchel
(b) Address: Poplar Bluff Mo
19. (a) 4-4-44 (Date received local registrar) (b) Bella Penne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30 year 1944 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from 2-7, 1944, to 3-30, 1944; that I last saw her alive on 3-30, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma, lungs, stomach, + sigmoid colon.	Unknown
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: J. W. Fronda (M. D. ~~or other~~)
Address: Poplar Bluff, Mo. Date signed: 3-30-44

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 44-626
Date Filed 4-12-44

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~~ 3-30-4

....., Registered Apprentice No.....

working under my personal supervision.

Signed Philip A Fenchel

Licensed Embalmer No. 2936

P. O. Address Van Buren 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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. .....

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 107

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 in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Carter
(c) City or town: Elsinore
(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: Mary C. Ambrose
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex .....
5. Color or race .....
6. (a) Single, widowed, married, divorced .....
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 .....
MOTHER FATHER
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) ..... (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) 4-10-44 (Date received local registrar) (b) Belle Kime (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 Day 30 year 1944 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.

	Duration
Immediate cause of death	
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? ..... (Specify type of place)
While at work? ..... (c) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

14228

SUPPLEMENTARY