

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 11 1947  
333

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38969A  
Registrar's No. 26

Registration District No. \_\_\_\_\_

Primary Registration District No. 2074

1. PLACE OF DEATH:

(a) County SCOTT  
(b) City or town Sikeston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 722 Lake St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard  
(c) City or town Essex  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

SARAH MILITHA TISDIAL

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 J.A.

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

7. Birth date of deceased Jan 1 (Month) (Day) (Year)

1856 (Year)

8. AGE: Years 88 Months 8 Days 3

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Morgan

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

14. Maiden name OK

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant J.A. Tisdial

(b) Address Essex Mo

17. (a) Burial (b) Date thereof 8-4-44 (Month) (Day) (Year)

(c) Place: burial or cremation Essex Mo

18. (a) Signature of funeral director Welch Funeral Home

(b) Address Sikeston Mo

19. (a) 4-3-47 (Date received local registrar) (b) Mrs. T. G. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2 year 1944 hour 10:00 minute P. M. 7-31-47  
21. I hereby certify that I attended the deceased from 8-2 1944 to 8-2 1944  
that I last saw him alive on 8-2 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac De-compensation  
Due to Essential Hypertension  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature E. A. Urban (M. D. or other) M.D.  
Address Sikeston Mo Date signed 8-12-47

303 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2

District File Number 447-52

Date Filed 4-9-77

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston, Mo

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.