

FILED MAY 10 1945

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

Primary Registration District No. 3010

Registrar's No. 116

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

6  
1  
4

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:  
137 So Spanish  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 25 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) county Cape Girardeau

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

(d) Street No. 137 So Spanish  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME EMMA BACKUS

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 W. W. BACKUS 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased: OCT 4 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 8 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace Mt Vernon Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Wife

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

12. Name James Bruce

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

14. Maiden name Elizabeth Jones

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

16. (a) Informant H. H. Backus

(b) Address Cape Girardeau Mo

17. (a) Buried (b) Date thereof 4-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral

18. (a) Signature of funeral director H. H. Backus

(b) Address Cape Girardeau Mo

19. (a) 1945 (b) H. H. Phelps  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12  
year 1945 hour 12 minute 30 A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw her or alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration \_\_\_\_\_

Due to Hypertension

Due to \_\_\_\_\_

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

Major findings:  
Of operations None

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)

Means of injury 3

23. Signature Dr. J. P. Sigmund (M. D. or other) \_\_\_\_\_  
Address Jackson Mo Date signed 4/13/45

RECEIVED

District Health Officer No. 4  
District File Number 54-5-586  
Date Filed 5-7-45

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

*Emma Beckus*, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *J. Hawell*  
Licensed Embalmer No. *2390*  
P. O. Address *Cape*

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.