V. S. No. 2
OM—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 19 1945

Registration District No. 2 2

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14694

Primary Registration District No. 3074

Registrar's No.

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: Sikeston Gen. Hosp. D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 418 William
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME Ocie Lorene Britt

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 27 (Day) 1943 (Year)

8. AGE: Years 1 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Sikeston (City, town, or county) Mo. D (State or foreign country)

10. Usual occupation ✓

11. Industry or business ✓

FATHER
12. Name John Britt
13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Helen Davis
15. Birthplace Cape Girardeau (City, town, or county) Mo. D (State or foreign country)

16. (a) Informant John Britt
(b) Address Sikeston, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director Orville Taylor
(b) Address Sikeston, Mo.

19. (a) 4/7/45 (Date received local registrar) (b) Louise Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1945 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from March 8, 1945 to March 9, 1945
that I last saw her alive on March 9, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	3
Due to	
Due to	
Other conditions Severe Secondary Acnemia (Include pregnancy within 3 months of death)	3

Major findings:
Of operations
Of autopsy 107

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)
While at work? (e) Means of injury

23. Signature J. C. McClure (M. D. ~~or other~~)
Address Sikeston Date signed 3-14-45

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 45-608
Date Filed 7/14/45

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.....

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

working under my personal supervision.

Body not Embalmed

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, fact should be so stated above.