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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18400

Registration District No. 342 Primary Registration District No. 6153 4504 Registrar's No. 4

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Advance Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

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

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 774

(a) State Ark (b) County Miss

(c) City or town Blytheville 22 (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 Mrs Cara Sutton

3. (b) If veteran, name war No

3. (c) Social Security No. —

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife —

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

7. Birth date of deceased Oct (Month) 27 (Day) 1861 (Year)

8. AGE: Years 83 Months 6 Days 17 If less than one day hr. min.

9. Birthplace Rutherfordton (City, town, or county) N.C. 1 (State or foreign country)

10. Usual occupation House keeper

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Mrs Vadma Zimmer

(b) Address Cape Girardeau Mo

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 5-16-45 (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau Mo

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

(b) Address Blytheville Ark

19. (a) 5/28/45 (Date received local registrar) (b) M. R. Thruwer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1945 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from , 1944 to May 14, 1945 that I last saw her alive on May 8, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to Broken hip	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Dr. E. C. Masters (M. D. or other) D.O.

Address Advance, Mo Date signed 5-15-45

1131

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 645-762
Date Filed 6-6-45

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.

Signed Jas. R. Stovall

Licensed Embalmer No. 3108

P. O. Address Blythenville Ark.

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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 342 Primary Registration District No. 4504 Registrar's No. 4

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Advance
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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 Cara Sutton
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 wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 27 1866 (Month) (Day) (Year)
8. AGE: Years 83 Months 4 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or Business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
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) Fell at Home
(b) Date of occurrence broke Hip
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

18400