

FILED JAN 14 1946

State File No. ....

Registration District No. 238

Primary Registration District No. 4255

Registrar's No. 112

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: No 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No.  
(Specify whether  
In this community all of life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town New Madrid  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME EARLINE FRANCIS DANIELS

3. (b) If veteran, name war NO  
3. (c) Social Security No. NO

4. Sex FEMALE 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: Oct - 13 - 1945  
(Month) (Day) (Year)

8. AGE: Years 1 Months 1 Days 17  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: SIKESTON Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation: Child

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

12. Name: Laurence Daniels

13. Birthplace: Vienna Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name: Georgia Francis Atkins

15. Birthplace: New Madrid Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant: Laurence Daniels

(b) Address: New Madrid Mo.

17. (a) Burial (b) Date thereof: 11/29-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mounts

18. (a) Signature of funeral director: Richardson and Co

(b) Address: New Madrid

19. (a) 12-21-45 (b) Hubert Louis Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29  
year 1945 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 11/29/45  
Nov 29<sup>th</sup> 1945, to Nov 29, 1945  
that I last saw her alive on Nov 29, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia Duration \_\_\_\_\_

Due to: Aspiration of Kerosene

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

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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)

23. While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

Signature: O.B. Chandler (M. D. or other) M.D.

Address: New Madrid Mo. Date signed: 12/14/45

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

136

RECEIVED

District Health Office No. 2

District File Number

146-92

Date Filed

1-11-46

**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

*Leo Hudgyn*

Licensed Embalmer No.

3803

P. O. Address

*New Madrid*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan 112  
Registrar's No. 112

Registration District No. 238 Primary Registration District No. 4355

1. PLACE OF DEATH:  
(a) County New Madrid  
(b) City or town New Madrid  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

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 Earline F. Daniels  
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 5  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 13 (Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace MO (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan Day 9 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Nov 29 - 1945  
(c) Where did injury occur? New Madrid MO (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury Inhaled

23. Signature OB Chandler (M. D. or other) \_\_\_\_\_

Date signed 1/12/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

41931