

No. 2  
9-4-41  
5-17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22420

State File No. \_\_\_\_\_

FILED JUL 8 1946  
Registration District No. 23

Primary Registration District No. 3074

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston Mo

(c) Name of hospital or institution: Sikest ave 14  
(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 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott / 100

(c) City or town Sikeston Mo. R. F. D. 0  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Florence Woods

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

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced W /

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

7. Birth date of deceased 12 27 1898  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>5</u>	<u>4</u>	____ hr. ____ min.

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

10. Usual occupation Housewife

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

12. Name Unknown

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 W.T. Woods

(b) Address Bertrand, Mo. R.F.D. # 1

17. (a) Burial (b) Date thereof 6/4/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston, Mo.

19. (a) 6-28-46 (b) Mrs. T. Henry  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 1  
year 1946 hour 5 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 3-29-46  
19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him W alive on 6-23-46 and that death occurred on the date and hour stated above.

Immediate cause of death Cordeo-Renal vascular disease

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

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

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

Major findings: Of operations 1-3/4  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature James E. McClure M.D. (Seal)  
Address Sikeston, Mo. Date signed 6-3-46

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

212883

RECEIVED

District Health Office No. 2,

District File Number 746-30467

Date Filed 7-3-46

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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.....

..... Embalmed ....., Registered Apprentice No.....  
working under my personal supervision.

Signed John Martin

Licensed Embalmer No. 2941

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.**