

No. 2  
9-4-41  
5-17-39  
K2948A

STANDARD CERTIFICATE OF DEATH

State File No. **32941**

**FILED NOV 3 1 1946**

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

Primary Registration District No. **3010**

Registrar's No. **348**

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: **St Francis Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 hours**  
(Specify whether years, months or days) **50 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cape Girardeau**  
(c) City or town **Jackson**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Katie Marie Drum**

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 **Widowed**

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

7. Birth date of deceased **July 3 1896**  
(Month) (Day) (Year)

8. AGE: Years **50** Months **3** Days **19** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Cape Girardeau Co MO.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Domestic**

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

12. Name **R.L. Dickerson**

13. Birthplace **Cape Girardeau Co. MO.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Annie E. Loos**

15. Birthplace **Cape Girardeau Co. MO.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Victor Dickerson**  
(b) Address **Jackson MO.**

17. (a) **Burial** (b) Date thereof **Oct 23, 46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Russel Heights Cem**

18. (a) Signature of funeral director **Wilson D. Baker - Seaburg**  
(b) Address **Jackson MO.**

19. (a) **10-26-1946** (b) **G. E. Summers**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **21**  
year **1946** hour **3** minute **P** M.

21. I hereby certify that ~~he~~ she died the deceased from **Feb 21 1946** to **Feb 21-3 PM 1946**  
that I last saw ~~her~~ her alive on **Feb 21-2 PM 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Meningitis**  
Due to **chronic otitis media**

Duration **2 days**

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? **0**

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

23. Signature **G. E. Summers** (M. D. or other) \_\_\_\_\_  
Address **Jackson MO** Date signed **10-22-46**

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

31769

MOTHER FATHER

JAN 2 1954

RECEIVED

District Health Officer No. 4  
District File Number 1046-280  
Date Filed 10-28-46

NOV 3 1954

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 Glenn Wilson  
Licensed Embalmer No. 2828  
P. O. Address Jackson 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.

Registration District No. 53 Primary Registration District No. 3010

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:  
(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) (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Katie M. Drum

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 July 3  
(Month) (Day) (Year)

8. AGE: Years 50 Months 3 Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month \_\_\_\_\_ Day \_\_\_\_\_  
Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. In immediate cause of death \_\_\_\_\_

Due to Meninges from chronic otitis media

Due to 1st epidemic of tubercular

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

Major findings:  
Of operations \_\_\_\_\_  
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)  
(c) Means of injury \_\_\_\_\_

23. Signature J. W. ... (M. D. or other) \_\_\_\_\_  
Address Jump on the Date signed 11-6-46

**SUPPLEMENTARY**

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

31769

32941