S. No. 2
M—5-43
. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8520

Registration District No. 108 Primary Registration District No. 5423 Registrar's No. 15

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Arbyrd
(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 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Dunklin
(c) City or town Arbyrd
(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 VINA WILMOTH
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
77	11	5	hr. min.

9. Birthplace Unknown (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Housewife
11. Industry or business .....
FATHER
12. Name Unknown
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant A. W. Wilmoth
(b) Address Arbyrd, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Cemetery, Sarah, Mo.
18. (a) Signature of funeral director W. T. Howard
(b) Address Leachville, Ark.
19. (a) 4-2-47 (Date received local registrar) (b) Mrs J. H. Lanier (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12 year 1947 hour 3:45 PM minute ..... M.
21. I hereby certify that I attended the deceased from 9 Feb 1947 to 9 Feb 1947 that I last saw h. ex alive on 9 Feb 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Senility	Duration
Due to Heart Failure	
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) .....
(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 T N Rodman (M. D. or other) MD
Address Leachville Ark. Date signed 13 Feb 47

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No 2,
District File Number 447-506
Date Filed 4-8-47

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 H. H. Howard

Licensed Embalmer No. 3959

P.O. Address Leachville, 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.