

S. No. 2
M-9-4-41
v. 5-17-39
P-I X29484

State File No. **39029**
Registrar's No. **249**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED DEC 15 1947
Registration District No. **238**

Primary Registration District No. **5823**

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural
(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 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 15 miles So. West of Sikeston
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dwight Gene Taber

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 7 22 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 16 hr. min.

9. Birthplace Sikeston No. 1
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Lacy Burl Taber
13. Birthplace Lundsford Ark.
(City, town, or county) (State or foreign country)
14. Maiden name Eva Lancaster
15. Birthplace Matthews Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Lacy Burl Taber

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

17. (a) Burial (b) Date thereof 11/9/47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address Sikeston, Mo.

19. (a) 11-15-47 (b) Helen Louise Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 8
year 1947 hour 9 minute a M.

21. I hereby certify that I attended the deceased from 7-22 1947 to 11-8 1947
that I last saw him alive on 11-8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure Duration _____

Due to intestinal obstruction

Due to incarcerated inguinal hernia

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
157 M

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 Aldert P. Sargent (M. D. or other) MD.
Address Sikeston, Mo. Date signed 11-9-47

RECEIVED

District Health Office No. 2,

District File Number 1242-1578

Date Filed 12-11-47

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

John Allerton

Licensed Embalmer No. 2941

P. O. Address Superior Ave

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.