

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44499

State File No. _____

BUREAU OF THE CENSUS
FILED JAN 22 1948

Nienstedt
Registration District No. 238

Primary Registration District No. 5823

Registrar's No. 261

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 2 years

3. (a) PRINT FULL NAME Sharion J. Sinclair

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 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 10 / 15 / 1945
(Month) (Day) (Year)

8. AGE: Years 2 Months 1 Days 28

If less than one day hr. _____ min. _____

9. Birthplace Gideon / Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Bill Sinclair / 0

13. Birthplace Kennett / Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Clemmons

15. Birthplace Kennett / Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jeff Sinclair

(b) Address Sikeston, Mo.

17. (a) Burial (b) Date thereof 12/14/47
(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) 1-10-48 (b) Nelson Louis Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid / 72

(c) City or town Rural
(If outside city or town limits, write "RURAL") / 3

(d) Street No. Matthews, Mo. R.F.D. #2
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 13
year 1947 hour 3 minute 30 a.m.

21. I hereby certify that I attended the deceased from 12-12, 1947, to 12-13, 1947
that I last saw him alive on 12-12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria

Due to _____

Due to _____

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

Major findings: Of operations 10

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? _____

While at work? _____
(Specify type of place) (Means of injury)

23. Signature Nienstedt / 0 (M. D. or other) _____
Address Sikeston, Mo. Date signed 12-14-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1-10-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 148-123

Date Filed 1-19-68

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 Sefton

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.