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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH

BUREAU OF THE CENSUS
FILED APR 22 1948
Sargent 333

STANDARD CERTIFICATE OF DEATH

State File No. 15134

Registration District No.

Primary Registration District No. 3074

Registrar's No. 45

1. PLACE OF DEATH:

(a) County: Scott
(b) City or town: Sikeston
(c) Name of hospital or institution: 107 Daniel
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 18 years
In this community: 18 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott
(c) City or town: Sikeston
(d) Street No.: 107 Daniel
(e) Citizen of foreign country? no
If yes, name country:

3. (a) PRINT FULL NAME

Ida Lee Oller

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: 9

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive: 11 years

7. Birth date of deceased: 10 (Month) 11 (Day) 1880 (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	5	12	hr. min.

9. Birthplace: Fordsville Ky. (City, town, or county) (State or foreign country)

10. Usual occupation: Retired House wife

11. Industry or business:

12. Name: C. M. Smith

13. Birthplace: Unknown (City, town, or county) (State or foreign country)

14. Maiden name: Mary Ellen Johnson

15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Virginia Dalrymple (b) Address: Sikeston, Mo. 107 Daniel

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/25/48 (Month) (Day) (Year)

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

18. (a) Signature of funeral director: H. W. Albritton (b) Address: Sikeston, Mo.

19. (a) 4-14-48 (Date received local registrar) (b) Mrs. J. F. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 3 day: 23 year: 1948 hour: 12 minute: 15 p.m.

21. I hereby certify that I attended the deceased from 1-21 1948 to 3-23 1948 that I last saw her alive on 3-13 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure

Due to: Ventricular fibrillation

Due to: Atrio-ventricular block

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

Major findings: Of operations: 95A 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? (d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature: Alden Sargent (M. D. or other) Sikeston Mo Date signed: 3-27-48

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Office No. 2,
District File Number 448-2715-
Date Filed 4-19-48

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 A. [Signature]
Licensed Embalmer No. 2941
P. O. Address [Signature]

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. 333

Primary Registration District No. 3074

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Liberton
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Ida See Miller

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 Earl Miller of nee 6. (c) Age of husband or wife if alive deceased

7. Birth date of deceased ac 11
(Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Retired housewife
(City, town, or county) (State or foreign country)

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) 4-30-48 (b) Mrs J F Henry
(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 May Day 13 Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-15134