

FILED OCT 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31179

BIRTH NO. 124 REG. DIST. NO. 239 PRIMARY REG. DIST. NO. 5825 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Baderville (Como Rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Baderville (Como Rural)</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>Lewis 73</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Arthur</u> b. (Middle) <u>Lee</u> c. (Last) <u>Street</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 5 1949</u>
--	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>infant</u>	8. DATE OF BIRTH <u>Aug 30, 1949</u>	9. AGE (In years last birthday) <u>—</u> MONTHS <u>—</u> DAYS <u>6</u> IF UNDER 1 YEAR Hours <u>—</u> Min. <u>—</u>
--------------------	-------------------------------	--	--------------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>New Madrid Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
---	---	---	---

13a. FATHER'S NAME <u>Willie Henry Street</u>	13b. MOTHER'S MAIDEN NAME <u>Louise Goode</u>	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Willie Street R#1 Wilbourn Mo</u>	ADDRESS
--	---	--	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>6 days</u>  <u>776X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Baby</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>malnutrition</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Aug 30, 1949, to Sept 4, 1949, that I last saw the deceased alive on Sept 5, 1949, and that death occurred at 3:09 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Quinn M. Ramey M.D.</u> (Degree or title)	23b. ADDRESS <u>1 Cassin Ave</u>	23c. DATE SIGNED <u>Sept 1949</u>
---	----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept 6, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Portageville Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Portageville Mo</u>
---	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>10/18/49</u>	REGISTRAR'S SIGNATURE <u>Arthur Lee Street</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Delisle Funeral Parlor</u> ADDRESS <u>Portageville, Mo</u>
--	--	--

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

RECEIVED OCT 10  
District Health Office N  
District File Number 1044  
Case Filed

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

*Not Embalmed*

Student Embalmer No.

working under my personal supervision.

Signed

Signed  
Student Embalmer

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.