N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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REC'D JUL 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22717
Do not use this space.

1. PLACE OF DEATH
(a) County Mississippi 2 Registration District No. 566
(b) Township Cinnapitty 1 Primary Registration District No. 5762 Registered No. 64
(c) City Charleston (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 416 George Colbert
(a) Residence, No. County Farm St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not Known
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE About YEARS 60 MONTHS X DAYS X If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Not Known
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known ?

FATHER
13. NAME Not Known ?
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known ?

MOTHER
15. MAIDEN NAME Not Known
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

17. INFORMANT (ADDRESS) Rube Bush Charleston Mo
18. BURIAL, CREMATION, OR REMOVAL Oak Grove Cemetery
PLACE Charleston Mo DATE 6/21 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lair-Nunnelee Service Charleston Mo
20. FILED 6-22, 1939 F S Vernon
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/20, 1939
22. I HEREBY CERTIFY, That I attended deceased from April 16, 1939 to June 20, 1939
I last saw him alive on June 15, 1939. Death is said to have occurred on the date stated above, at 11:45 p.m.
The principal cause of death and related causes of importance were as follows:
Mitral Insufficiency
Date of onset
131
Other contributory causes of importance:
Chronic Brights disease
Name of operation None Date of
What test confirmed diagnosis? Cl Sy Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) F S Vernon, M. D.
745 (Address) Charleston Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2
District File Number 239-59
Date Filed 7-11

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.