

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

26325
Do not use this space.

REC'D AUG 3 1939

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 604
 (b) Township 1 Primary Registration District No. 4358
 (c) City New Madrid (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Floyd Washington
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MA 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 26-1938
 7. AGE YEARS ✓ MONTHS 9 DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 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) Catron Mo.
 FATHER 13. NAME Erroll Washington
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn
 MOTHER 15. MAIDEN NAME Roxie Deane
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.
 17. INFORMANT (ADDRESS) Roxie Deane
New Madrid Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Catron Mo DATE June 27 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Richards and Co
New Madrid Mo
 20. FILED 7/19 1939 Wm O'Bannon
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 26 1939
 22. I HEREBY CERTIFY That I attended deceased from 6-25, 1939, to 6-26, 1939
 I last saw h. i. m. alive on 6-26, 1939 Death is said to have occurred on the date stated above, at 7:00 p. m.
 The principal cause of death and related causes of importance were as follows:
Cholin - m
Severe dehydration
 Date of onset 6-17-39
 Other contributory causes of importance: 119b
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) D. P. [Signature], M. D.
522 (Address) New Madrid

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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RECEIVED

District Health Officer No. 2,

District File Number 839-100

Date Filed 8-2

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 comply with the above constitutes grounds for revocation of license.)

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