

SEP 6 1939

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

29717
Do not use this space.

1. PLACE OF DEATH

(a) County Mississippi Registration District No. 566
 (b) Township Mississippi Primary Registration District No. 3030
 (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

(a) Residence, No. 320 Anna Betts
Locust Street, Charleston Mo. 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ephram W. Betts

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 4, 1888

7. AGE YEARS 51 MONTHS 0 DAYS 10 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. House Keeper
 10. Date deceased last worked at this occupation (month and year) June 19, 1939 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gaston, Alabama

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) Eligah Betts
Charleston, Mo.

18. BURIAL CREMATION, OR REMOVAL PLACE Oak Grove Cemetery DATE 8/14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Nunnlee Funeral Service
Charleston, Mo.

20. FILED 8-15-39 J. D. Gorman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/13 1939

22. I HEREBY CERTIFY, That I attended deceased from July 13 1939, to Aug 13 1939
 last seen alive on Aug 12 1939. Death is said to have occurred on the date stated above, at 6:00 A. M.
 The principal cause of death and related causes of importance were as follows:

Date of onset July 13, 1939
Toxemia of Dry gangrene.

Other contributory causes of importance:
Surgery on deaf toe.

Name of operation Amputation Date of June 24
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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?
 If so, specify _____ (Signed) Saul A. Baw M. D.
Charleston Mo. (Address)

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.

98

RECEIVED

District Health Officer No. 2,

District File Number 939-173

Date Filed 9-2

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.....

John P. Kummeler Jr

....., Registered Apprentice No.....

working under my personal supervision.

Signed *John P. Kummeler Jr*

Licensed Embalmer No. 3851

P. O. Address Charleston, S.C.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Mississippi Registration District No. 566
(b) Township..... Primary Registration District No. 3030 Registered No.....
(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 Anna Bettes

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-13 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin. 21 0 10

The principal cause of death and related causes of importance were as follows:

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.
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

Typhoid & Dry gangrene
Atherosclerosis 97

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance: Surgery on Inf toe

FATHER 13. NAME

Name of operation..... Date of.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis?..... Was there an autopsy?.....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Accident, suicide, or homicide?..... Date of injury....., 19.....

17. INFORMANT (ADDRESS)

Where did injury occur?..... (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE DATE 19

Manner of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury.....

20. FILED 19

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify Paul S. Bauer, M. D.
(Signed) Charleston mo
(Address)

Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

