

REG SEP 13 1939

Registration District No. 267

Primary Registration District No. 6763

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Rural
(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 45 (Specify whether years, months or days)

3. (a) PRINT FULL NAME JESSE SAMUEL WHITE
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Shara Brunner White 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased Oct. 8, 1854 (Month) (Day) (Year)

8. AGE: Years 80 1/2 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Webster Co., Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business
12. Name William White
13. Birthplace Mo. (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth McElhannon
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Tom White
(b) Address East Prairie, Mo.

17. (a) Burial (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Armeton, Mo.

18. (a) Signature of funeral director Thomas Shilly
(b) Address East Prairie, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Mississippi
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Aug day 19th year 1939 hour 10 1/4 minute M.

21. I hereby certify that I attended the deceased from Aug 15, 1939 to Aug 19, 1939; that I last saw him alive on Aug 15, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Ca of stomach (Primary) Duration D.K.

Due to 46

Other conditions (include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations none
Of autopsy none
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) X
(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 E. C. Salmons (M. D. or other)
Address East Prairie, Mo. Date signed 8/22/39

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 very important.

RECEIVED

District Health Officer No. 2,

District File Number 929-206

Date Filed 9-11

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

Travis N. Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie, Mo.

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.

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

29722

Do not use this space.

1. PLACE OF DEATH

(a) County Mississippi Registration District No. 567
(b) Township St. James Primary Registration District No. 5763 Registered No. 61
(c) City _____ (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

Jesse Samuel White
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-19-1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 10 11

Date of onset

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

Other contributory causes of importance:

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

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

FATHER
13. NAME

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

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.

MOTHER
15. MAIDEN NAME

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

Manner of injury _____
Nature of injury _____

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

20. FILED Sept 5 - 1939 Mrs. O. M. Hodges
Local Registrar

(Signed) E. Charles Robinson, M. D.
(Address) Charleston

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

