

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

36686
Do not use this space.

1. PLACE OF DEATH: **Mississippi** (Stamp: NOV 14 1939)
 (a) County: **Mississippi** Registration District No. **566**
 (b) Township: **Lywappity** Primary Registration District No. **3030**
 (c) City: **Charleston** (d) Street No. _____ Registered No. **108**
 (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: **Simmie Curry**
 (a) Residence, No. **306 Heggie** 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 Male	4. COLOR OR RACE Color	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella Curry				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 20, 1872				
7. AGE 67	YEARS	MONTHS 0	DAYS 15	IF LESS than 1 day,hrs. ormin.
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. Farmer			
	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) Marshall County Miss				
FATHER	13. NAME Josiah Curry			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Carolina			
MOTHER	15. MAIDEN NAME Madora Coleman			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi			
17. INFORMANT (ADDRESS) Ida May Smith Holly Springs Miss				
18. BURIAL, CREMATION, OR REMOVAL PLACE Charleston Mo Oak Grove DATE 10/16 39				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lair-Nunnelec Charleston Mo				
20. FILED 18-26-1939 F. J. Stinson Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-15-1939	
22. I HEREBY CERTIFY, That I attended deceased from 10/11 19 39 to 10/15 19 39 I last saw h. 14 alive on 10/14 19 39 . Death is said to have occurred on the date stated above, at 3:50p . The principal cause of death and related causes of importance were as follows: General Paralysis Date of onset DK.	
Other contributory causes of importance: Senility	
Name of operation no	Date of _____
What test confirmed diagnosis? El. Symp.	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: Ch. Paralysis (Signed) Chas. K. ... M. D. 745 (Address) Charleston, Mo.	

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

83

RECEIVED
DISTRICT HEALTH OFFICER
DISTRICT HEALTH OFFICER

RECEIVED

District Health Officer No. **2**,

District File Number 1139-299

Date Filed 11-1

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

36686
Do not use this space.

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

65 Simmie Osery
(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 m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 0 15

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 · 15 · 1937

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

General paresis Date of onset _____
(Senile)
Other contributory causes of importance: Alcohol 1/2

Name of operation _____ Date of _____
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) E. C. Ray M. D.
(Address) Charleston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement, OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

