

67
 FEBRUAN 8 1939

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

44060
 Do not use this space.

1. PLACE OF DEATH
 (a) County Mississippi Registration District No. 569
 (b) Township Ohio Primary Registration District No. 5763
 or Wyatt
 (c) City Wyatt (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 Sarah Burnett
 (a) Residence, No. 653 Wyatt, Missouri 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 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 James Burnett

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 15, 1875

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 X X

OCCUPATION
 8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. housewife.
 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) Itawomba County Mississippi

FATHER
 13. NAME Robert McDuffy
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

MOTHER
 15. MAIDEN NAME Mollie Jones
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atlanta Georgia

17. INFORMANT (ADDRESS) David Burnett Wyatt, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cemetery DATE 12/17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lair* Nunne lee Charleston, Missouri.

20. FILED 12-18 1939 F. J. Vernon
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/15 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-13- 1939, to _____, 19____
 I last saw her alive on 12-13- 1939. Death is said to have occurred on the date stated above, at 11:45 A.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage with Left Hemiplegia
 Date of onset _____

Other contributory causes of importance: 82 W

Name of operation _____ Date of _____
 What test confirmed diagnosis? none 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? _____
 If so, specify _____
 (Signed) W. A. Singa M. D.
 (Address) 211 S. 3rd St. Charleston

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. S. N. 2.
 50M-9-19-38
 I X16805

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.

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 *John P. Munnelle Jr*
Licensed Embalmer No. *3851*
P. O. Address *Charleston 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.