

FILED MAR 7 - 1940

Registration District No. 604 Primary Registration District No. 5802 Registrar's No. _____

42
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rural - New Madrid

(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 _____ (Specify whether _____)

In this community _____ (years, months or days) 640

3. (a) PRINT FULL NAME GEORGE TERRELL

8. (b) If veteran, name war unk 8. (c) Social Security No. unk

4. Sex male 5. Color or race col 6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased about 1885

(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

about 55 _____ hr. _____ min.

9. Birthplace unk (City, town, or county) (State or foreign country) 9

10. Usual occupation laborer 9

11. Industry or business lumber - cutter 9

12. Name unk

13. Birthplace unk (City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant Allis Engle

(b) Address East Prairie, Mo

17. (a) Burial (b) Date thereof Feb 16 1940

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Madrid

18. (a) Signature of funeral director None

(b) Address _____

19. (a) 2/19/1940 (b) Wm. O. Sanner

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State unk (b) County unk

(c) City or town _____ (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 Feb day 15 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Gun shot wound in head

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 193

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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) None

(b) Date of occurrence Feb 14

(c) Where did injury occur? New Madrid, county, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature J. A. Roberts (M. D. or other) 15

Address New Madrid Date signed 2-16-40

RECEIVED

District Health Officer No. 2,

District File Number 340-66

Date Filed 3/4/40

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.