

Registration District No. 379

Primary Registration District No. 5765

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Rural - Ohio Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2 mi. So. E. of Wyatt, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lucinda English

3. (b) If veteran, name war X X X 3. (c) Social Security No. X X X

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

6. (b) Name of husband or wife Oral English 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased March 19 1919  
(Month) (Day) (Year)

8. AGE: Years 20 Months 11 Days 25  
If less than one day hr. min.

9. Birthplace Little Rock Arkansas/  
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business At home

MOTHER FATHER  
12. Name John Turner  
13. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Fannie Craig  
15. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Oral English  
(b) Address Box 789 0 Wyatt, Mo.

17. (a) Burial (b) Date thereof 3-17-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director John P. Hummel  
(b) Address Charleston, Mo.

19. (a) 3-17-40 (b) J. D. Brown 745  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
(c) City or town Rural - Ohio Township  
(If outside city or town limits write "RURAL")  
(d) Street No. 2 mi. So. E. of Wyatt, Mo.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14th.  
year 1940 hour 2 minute P.M.

21. I hereby certify that I attended the deceased from March 1.  
40, 1940, to March 14, 1940;  
that I last saw her alive on March 13., 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Pulmonary Tuberculosis Duration 6 mo.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy none

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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 Paul S. Bair (M. D. or other)  
Address Charleston Date signed 3/14/40

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

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RECEIVED

District Health Officer No. 2

District File Number 440-853

Date Filed 4/4/49

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. Nimmiche Jr*

Licensed Embalmer No. 3851

P. O. Address Charleston

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.