

Registration District No. 400

Primary Registration District No. 55530

Registrar's No. 83

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Paris Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Jackson County Home for the aged 3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Unknown (b) County Unknown
 (c) City or town Unknown
(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.

3. (a) PRINT FULL NAME Tina Frick (24)
 3. (b) If veteran, name war W
 3. (c) Social Security No. W

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Apr day 18
 year 1940 hour 5 minute 15 a.m.

4. Sex Female 5. Color or race W
 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 16 1860
(Month) (Day) (Year)

I hereby certify that I attended the deceased from Jan 1 1940 to 4-18 1940
 that I last saw alive on 4-16 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years 89 Months 11 Days 2
 If less than one day _____ hr. _____ min.

Immediate cause of death senile debility
 Duration _____

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

Due to _____
 Due to lipid

10. Usual occupation Housewife

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

11. Industry or business _____
 12. Name Unknown
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Ernest Jackson
 (b) Address 90 P.C. Home

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Burial (b) Date thereof 4/20/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? 93
(Specify type of place)
 While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director Wesley V. Low
 (b) Address 646 State, S. C. Res.

23. Signature W. Greene (M. D. seal)
 Address Independence Date signed 4/18/40
mo

19. (a) 4-18-40 (b) Dora J. Barnes
(Date received local registrar) (Registrar's signature)

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.....

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.