

S. No. 2  
—11-10-39  
v. 5-17-39  
I X21422

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

19015

State File No. \_\_\_\_\_

FILED JUN 6 1940-67

Registrar's No. 71

Registration District No. 567 Primary Registration District No. 5765

**1. PLACE OF DEATH:**

(a) County Mississippi *Ohio*

(b) City or town Wyatt  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
no street numbers  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community 5 mo.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Mississippi

(c) City or town Wyatt,  
(If outside city or town limits, write "RURAL")

(d) Street No. no street numbers  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Jessie Mae Green *650*

3. (b) If veteran, name war X X X

8. (c) Social Security No. X X X X

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 17  
year 1940 hour 2 minute 40 A. M.

4. Sex Female

5. Color or race Col.

6. (a) Single, widowed, married, divorced infant

6. (b) Name of husband or wife X X X

6. (c) Age of husband or wife if alive X X years

7. Birth date of deceased: December 9 1939  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 14 1940 to May 17 1940  
that I last saw her alive on May 16 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
0 5 8 hr. \_\_\_\_\_ min.

Immediate cause of death Tobacco Pneumonia *6 da*

9. Birthplace: Wyatt Missouri  
(City, town, or county) (State or foreign country)

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

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

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

10. Usual occupation Infant

11. Industry or business X X X X X X X X

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

12. Name Gus Green

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

14. Maiden name Kathelena Roston

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

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

16. (a) Informant Gus Green

(b) Address Wyatt, Mo.

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature C. C. Greenlee (M. D. or other) \_\_\_\_\_  
Address Charleston Date signed May 18 40

17. (a) Burial (b) Date thereof 5-17-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Lair-Nunnelee Service

(b) Address Charleston, Mo.

19. (a) 5-18 40 (b) F. J. Greenlee  
(Date received local registrar) (Registrar's signature)

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

71

RECEIVED

District Health Officer No. 2.

District File Number 640-109

Date Filed 6/5/40

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**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.