

C. No. 5-17-39 I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19018

JUN 6 1940
Registration District No. 369

Primary Registration District No. 576

State File No. _____
Registrar's No. 64

1. PLACE OF DEATH: Mississippi *Clinton*
(a) County _____
(b) City or town Wyatt, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
In this community all of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Mississippi
(c) City or town Wyatt, Mo.
(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 Walter Carr *600*
(b) If veteran, X X X name war
(c) Social Security No. 491-16-0547

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 30
year 1940 hour 6 minute 45 P.M.

4. Sex Male
5. Color or race Col.
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife not known
6. (c) Age of husband or wife if alive X X years
7. Birth date of deceased not known
(Month) (Day) (Year)

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.

8. AGE: Years 67 Months - Days -
If less than one day hr. _____ min. _____

Immediate cause of death fallen in storm when their house blew away
Duration _____

9. Birthplace not known
(City, town, or county) (State or foreign country)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation farmer

Major findings: Of operations _____
Of autopsy _____

11. Industry or business farming
12. Name not known
13. Birthplace not known
14. Maiden name not known
15. Birthplace not known
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Clifford McIntyre
(b) Address Wyatt, Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence April 30 40
(c) Where did injury occur? at their home in County
(City or town) (County) (State)

17. (a) Burial (b) Date thereof 5-1-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Charleston Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
745 at home
While at work? _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director Lair-Nunnelee Service
(b) Address Charleston, Mo.

23. Signature Frank J. Vignone (Print name)
Address Charleston Mo Date signed _____

19. (a) B (b) ✓
(Date received by registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No.

District File Number 640-101

Date Filed 6/5/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19018
Registrar's No. 64

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 569

Primary Registration District No. 2762-

HOWENNA MOORE

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

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Ohio T. P.
(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

3. (a) PRINT FULL NAME Walter Carr

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

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 67 Months - Days - If less than one day _____ hr _____ min

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-9-40 (b) F. D. Vernon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(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 apr day 20
year 1940 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

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) _____

(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) _____ (b) Means of injury _____

23. Signature Frank D. Vernon _____ (City or town) _____ (State) _____ (or other)

Address Charleston _____ Date signed _____

SUPPLEMENTARY

S-19018