

Registration District No. 566

Primary Registration District No. 5762

Registrar's No. 77

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

1. PLACE OF DEATH:

(a) County Mississippi
 (b) City or town Tywadpity Township "Rural"
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4 miles N. E. of Charleston. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No.
(Specify whether years, months or days)
 In this community All life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Miss.
 (c) City or town Charleston, Rural.
(If outside city or town limits, write "RURAL")
 (d) Street No. 4 miles northeast.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Roxie Barnes 652

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

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

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

7. Birth date of deceased March 23 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>2</u>	<u>5</u>	hr. _____ min.

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

10. Usual occupation Housekeeper.

11. Industry or business XXX

MOTHER { 12. Name Pat Bradford

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

14. Maiden name Not known.

15. Birthplace Not known.
(City, town, or county) (State or foreign country)

16. (a) Informant James Barnes

(b) Address Charleston R#2

17. (a) Burial (b) Date thereof 5/28/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery.

18. (a) Signature of funeral director Fun. - Memorial Service

(b) Address Main St. Charleston Mo

19. (a) 5-30-40 (b) J. D. Vernon
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
 year 1940 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 1940 to May 28 1940
 that I last saw her alive on May 27 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Auricular fibrill DK

Due to Dyscordites
Hypertension
 Due to Chr. Nephritis

Other conditions 121
(Include pregnancy within 3 months of death)

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) _____
 (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?
745 (Specify type of place)
 While at work? _____ (b) Means of injury _____

23. Signature B. Chas. Alving (M. D. or other) 1
 Address Charleston Mo Date signed 5/30/40

RECEIVED

District Health Officer No. 2

District File Number 640 - 1089

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.