

Mo. 2
10-39
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X214

JUN 6 1940
Registration District No. 566

State File No. _____
Registrar's No. 65

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Bertrand
(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 5 mo. 24 days
In this community 5 mo. 24 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miss.
(c) City or town Bertrand
(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 Herschel Lee Pettis 320
3. (b) If veteran, name war X X X
3. (c) Social Security No. X X X

4. Sex Male
5. Color or race White
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 September 6th. 1939
(Month) (Day) (Year)

8. AGE: Years 0 Months 7 Days 24
If less than one day hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business X X X

MOTHER FATHER
12. Name Brownie Pettis
13. Birthplace Samburg Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Raney Dell Rogers
15. Birthplace not known Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Pettis
(b) Address Rt. 1. Bertrand, Mo.

17. (a) Burial (b) Date thereof 5-1-40
(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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

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.

Immediate cause of death Killed in storm when their house flew away

Due to _____
Due to _____

Other conditions 18 M
(Include pregnancy within 3 months of death) 1A

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence _____
(c) Where did injury occur? April 30 - 40
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
7450m farm out in County
While at work _____ (Specify type of place)
(e) Means of injury _____

23. Signature Frank J. Young (M.D. or other) S
Address Charleston Mo Date signed _____

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

RECEIVED

District Health Officer No.

District File Number 640-109

Date Filed 12/5/40

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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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 190 26

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 576

Primary Registration District No. 5762

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town Wynona, Miss.
(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 _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Herschel Lee Jett
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

8. AGE: Years Months Days If less than one day
7 24 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-9-40 (b) Frank S. 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 30
 year 1940 hour _____ minute _____ M.

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.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
 Of operations _____

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

23. Signature Frank S. Vernon (Date or other) _____
 Address Charleston, Miss. Date signed _____

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

S-19026