

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22303

State File No. _____

Registrar's No. 85

Registration District No. 576

Primary Registration District No. 5762

REC'D JUL 15 1940

1. PLACE OF DEATH

(a) County Mississippi

(b) City or town Wyatt, --Rural
(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 3 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

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

(d) Street No. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME Charlæe Nelson 1225

(b) If veteran, name war none

8. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24th
year 1940 hour 8 minute 20 p. M.

4. Sex Male

5. Color or race col

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

8. (b) Name of husband or wife none

8. (c) Age of husband or wife if alive none years

7. Birth date of deceased May 23rd, 1921
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-15-1940 to 6-20-1940
that I last saw him alive on 6-20-1940
and that death occurred on the date and hour stated above.

8. AGE: Years 19 Months 1 Days 1
If less than one day hr. _____ min. _____

Immediate cause of death Tuberculosis ✓

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

Due to Heart Failure

10. Usual occupation Farm Laborer

Due to Dislocation of the Heart

11. Industry or business Farming

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

MOTHER FATHER

12. Name Carrie Nelson

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

14. Maiden name Florence Roberts

15. Birthplace Beebee Arkansas
(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 Carrie Nelson

(b) Address Charleston, Mo R#2

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? _____

17. (a) Burial (b) Date thereof 6/26/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove-Charleston Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

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

(b) Address Charleston, Mo

19. (a) 6-27-40 (b) J. Overman
(Date received local registrar) (Registrar's signature)

23. Signature H. R. Marshall (M. D. or other) 1

Address 320 Pryor st Date signed 6-26-40

Maffield Ky

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

23

RECEIVED

District Health Officer No. _____

District File Number 740-11

Date Filed 7/5/40

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 John P. Munnell

Licensed Embalmer No. 3851

P. O. Address Charleston, W. Va.

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. 22303

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 566

Primary Registration District No. 5762

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Swampscott
(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

Charles Nelson

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

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

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 19 Months 1 Days 1 If less than one year, 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 June day 24 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I first saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of lungs Duration _____
Due to Heart failure

Due to Dilatation of the heart

Other conditions: (Include pregnancy within 3 months of death) 23

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) (e) Means of injury _____

23. Signature H. B. Marshall (M. D. or other) _____

Address Mayfield Rd signed _____

SUPPLEMENTARY

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

MOTHER FATHER

55303

22657
22735