DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 9 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

22483

State File No. _____

Registration District No. 654 Primary Registration District No. 5873 Registrar's No. _____

1. PLACE OF DEATH:
(a) County: Pemiscot County
(b) City or town: Rural Pemiscot
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3½ miles S.E. of Cooter
(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 all life

2. USUAL RESIDENCE OF DEACESED:
(a) State: Missouri (b) County: Pemiscot
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3½ miles S.E. of Cooter
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME: Jo Alice Thomas
3. (b) If veteran, name war: x
3. (c) Social Security No.: x

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: x
6. (c) Age of husband or wife if alive: x years
7. Birth date of deceased: January (Month) 26 (Day), 1940 (Year)

8. AGE: Years 0 | Months 3 | Days 9 | If less than one day _____ hr. _____ min.

9. Birthplace: Cooter, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: x
11. Industry or business: x

FATHER
12. Name: J. C. Thomas
13. Birthplace: Alamo, (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name: Ruby Clayton
15. Birthplace: Memphis, (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant's own signature: J. C. Thomas
(b) Address: Cooter, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/7/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Cooter, Mo.
18. (a) Signature of funeral director: La Forge Und. Co.
(b) Address: Caruthersville, Mo.
19. (a) 6-19-1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5 year 1940 hour 2 minute 3 A. M.
21. I hereby certify that I attended the deceased from May 4, 1940, to May 5, 1940; that I last saw he alive on May 4, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Unknown	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____
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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature: L. E. Cooper (M. D. ~~or other~~)
Address: Cooter, Mo. Date signed 5-8-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

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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 Not Embalmed, 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.

S. No. 2B
—2-21-40
I X22659

OWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22483

Registration District No. 654 Primary Registration District No. 5872 Registrar's No.

1. PLACE OF DEATH:
(a) County: Pemiscot
(b) City or town: Country
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME: Joe Valice Thomas.
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: S
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: 3 | Days: 9 | If less than one day: hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1 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) (e) Means of injury
23. Signature L. E. Cooper (M. D. or other)
Address Caruthersville Date signed

SUPPLEMENTARY