

Registration District No. 566

Primary Registration District No. 3030

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston
(c) Name of hospital or institution: Vine Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 years
In this community 16 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Will Hall
3. (b) If veteran, name war X X X
3. (c) Social Security No. 486-14-6640

4. Sex Male 5. Color Col. 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillie Hall 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased April 4 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 0 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Day laborer

12. Name Dont know

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

14. Maiden name Dont know

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

16. (a) Informant Lillie Hall

(b) Address Charleston, Mo.

17. (a) Burial (b) Date thereof 7-6-40
(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) 7-11-40 (b) J. J. Vernon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Charleston, Mo.
(If outside city or town limits, write "RURAL")
Vine Street
(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 July day 4th.
year 1940 hour 10 minute - A. M.

21. I hereby certify that I attended the deceased from July 3 - 4
1940 to July 4 1940
that I last saw him alive on July 3 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis Duration Dont know

Due to _____

Due to _____

Other conditions 93C
(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? 375
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. J. Pearson (M. D. or other) _____

Address Charleston Mo Date signed _____

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

7
3
1

25

RECEIVED

District Health Officer No. 2

District File Number 840-1282

Date Filed 8/2/40

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

E. C. Pennelee

Licensed Embalmer No. 4164

P. O. Address Charlton, Mo.

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.