FILED AUG 3 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25765

Registration District No. 566 | Primary Registration District No. 5762 | Registrar's No. 86

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

1. PLACE OF DEATH:

(a) County: Mississippi

(b) City or town: Charleston-Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural RT # 3
(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: 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Mississippi

(c) City or town: Charleston-----Rural
(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: Izory Sanders Eskew

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: Color

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

6. (b) Name of husband or wife: James Eskew

6. (c) Age of husband or wife if alive: 24 years

7. Birth date of deceased: June (Month) ____ (Day) 1900 (Year)

8. AGE: Years 40 | Months 1 | Days ### | If less than one day ____ hr. ____ min.

9. Birthplace: Johnson Grove (City, town, or county) Tennessee (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Forrest Sanders
13. Birthplace: Crochet County (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name: Mozella Rucker
15. Birthplace: Carter County (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant: Zedie Pate
(b) Address: 4422 Maffit Ave., St. Louis, Mo

17. (a) Both (Burial, cremation, or removal) (b) Date thereof: July 2, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Johnson Grove Tennessee

18. (a) Signature of funeral director: Lair-Nunnelee Funeral Service
(b) Address: Charleston, Mo

19. (a) 7-3-40 (Date received local registrar) (b) N D Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th year 1940 hour 2 minute 30 p M.

21. I hereby certify that I attended the deceased from 6/8/40, 19__, to 6/15, 1940, that I last saw her alive on 6/15, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Probably Dehydration as I had not seen her for 2 weeks	
Due to Hyperemesis Gravid.	1 mo
Due to Pregnancy ✓	6 wks
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
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? (Specify type of place)
While at work
(e) Means of injury

23. Signature: L Chas Lalwing (M. D. or other) MD.
Address: Charleston Mo. Date signed 7-2-40

(Licensed Embalmer's Statement on Reverse Side)

147

RECEIVED
District Health Officer No. 2,
District File Number 840-1280
Date Filed 8/2/40

MAY 20 1963

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 T. Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
—2-21-40
oI X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23-765

Registration District No. 366 Primary Registration District No. 5762 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Tywappity
(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 Izory Sanders Estes
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race Col
6. (a) Single, widowed, married, divorced M
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 40 Months 1 Days If less than one day 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) (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 June day 20 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 Probably Dehydration as I had not seen her for 2 weeks
Due to Hyperemesis Gravidarum
Due to Pregnancy
Other conditions No Delivery
(Include pregnancy within 3 months of death)
Major findings:
Of operations 147
Of autopsy

Duration
2 wks

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY