

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.

Registration District No. 657

Primary Registration District No. 4388

State File No. _____

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Genessee
(b) City or town Caruthersville
(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 6 mo - 15 da - 25 hr years, months or days)

3. (a) PRINT FULL NAME WILLIE M. LOGAN

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased 12 (Month) 24 (Day) 1939 (Year)

8. AGE: Years 0 Months 6 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Willie Logan
13. Birthplace Halls Springs Miss (City, town, or county) (State or foreign country)
14. Maiden name Archie Logan
15. Birthplace Halls Springs Miss (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willie Logan
(b) Address Caruthersville, Mo

17. (a) Burial (b) Date thereof 7-10-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caruthersville, Mo

18. (a) Signature of funeral director W. H. Hill
(b) Address 401 N. 5th St. Mo

19. (a) July 10, 1940 (b) Ada Martin (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Genessee
(c) City or town Caruthersville (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 July day 9 year 1940 hour 2:1 minute 7:5 P.M.

21. I hereby certify that I attended the deceased from 7-7-40 to 7-8-40

that I last saw her alive on 7-8-40 and that death occurred on the date and hour stated above.

Immediate cause of death undetermined Duration _____

natural causes ?

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 200 lb

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? 585

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

23. Signature U. J. Ogden (M. D. or other) _____

Address Caruthersville, Mo Date signed 7-10-40

8-40-29

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.