

No. 2
4-13-40
-17-1940
I X23159

JAN 20 1941

State File No. _____

Registration District No. 566

Primary Registration District No. 5762

Registrar's No. 168

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:
COUNTY FARM
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 25 YRS
years, months or days (Specify whether 3)

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 CHARLES CARRICO

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER, 29TH
year 1940 hour 12 minute 30 A.M.

4. Sex MALE

5. Color or race White

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 JANUARY 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from about May 1937, to Dec 29, 1940
that I last saw him alive on Dec 27, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 11 Days _____
If less than one day _____ hr. _____ min.

Immediate cause of death Influenza

Due to Chronic Tuberculosis Pulmonary & asthma

Due to _____

9. Birthplace TERRE HAUTE INDIANNA
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name N.K

13. Birthplace N.K
(City, town, or county) (State or foreign country)

14. Maiden name N.K

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant MRS LESLIE PATE

(b) Address CHARLESTON, MO 14

17. (a) BURIAL (b) Date thereof 12-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE CHARLESTON MO

18. (a) Signature of funeral director LAIR - NUNNELEE

(b) Address CHARLESTON, MO

19. (a) Dec 30 1940 (b) Frank J. Brown
(Date received local registrar) (Registrar's signature)

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? _____

Mo ESTON (Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature Frank J. Brown (M. D. or other) _____

Address Charleston Mo Date signed _____

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

RECEIVED

District Health Officer No. 2

District File Number 141-620

Date Filed 4/10/41

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, fact should be so stated above.