

Registration District No. 567

Primary Registration District No. 5763

Registrar's No. 1

1. PLACE OF DEATH: *Mississippi*  
(a) County  
(b) City or town *Rural St James*  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution *1 Day* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: *999*  
(a) State *Tenn* (b) County *Wentworth*  
(c) City or town *Tiptonville, Tenn* *40*  
(If outside city or town limits, write "RURAL")  
(d) Street No. *40* (If rural, give location)  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME *WALLACE E. LIGGINS*  
(b) If veteran, name war *World War* (c) Social Security No. *none*

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *January* day *8th*  
year *1941* hour *6* minute *P.* M.

4. Sex *Male* 5. Color or race *Col.* 6. (a) Single, widowed, married *Divorced*  
6. (b) Name of husband or wife *none* 6. (c) Age of husband or wife if alive *5* years

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.

7. Birth date of deceased *June 1, 1892*  
(Month) (Day) (Year)

Immediate cause of death *Fractured skull & crushed chest. Died instantly.*

8. AGE: Years *48* Months *7* Days *7* If less than one day hr. min.

Due to *Automobile accident*

9. Birthplace *Pine Bluff, Arkansas*  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

10. Usual occupation *shoe maker*

Other conditions (include pregnancy within 3 months of death)

11. Industry or business  
12. Name *Aburn Siggins*  
13. Birthplace *Douglas, Arkansas*  
(City, town, or county) (State or foreign country)  
14. Maiden name *Florence Lamb Rainey*  
15. Birthplace *Douglas, Arkansas*  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant *Florence Lamb Rainey*  
(b) Address *Grady, Arkansas*

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) *Accident* *17*  
(b) Date of occurrence *Jan. 8, 1941*

17. (a) *Burial* (b) Date thereof *1-12-41*  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation *Grady Ark*

(c) Where did injury occur? *East Prairie, Mississippi* Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
*8 Public highway*

18. (a) Signature of general director *W. Lewis Shelby*  
(b) Address *East Prairie Mo*

(e) Means of injury *Coroner* *3*  
While at work? *no* (Specify type of place)  
(e) Means of injury

19. (a) *Jan 2 41* (b) *Mrs. M. Hodges*  
(Date received local registrar) (Registrar's signature)

23. Signature *W. Lewis Shelby* (M. D. or other)  
Address *East Prairie, Mo.* Date signed *1-9-41*

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

MOTHER FATHER

1700  
98

RECORDED

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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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*Tavis Shelby*

Licensed Embalmer No. ....

*2726*

P. O. Address

*East Prairie, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3465-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 567

Primary Registration District No. 5763

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town St. James  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Wallace E. Liggins

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race col 6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 48 Months 7 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 8 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Fract. skull  
Crushed chest  
Died instantly

Due to Automobile accident

Due to Auto and truck collision on highway

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) acc

(b) Date of occurrence Jan 8 1941

(c) Where did injury occur? East Prairie, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Hwy

(Specify type of place) While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature James Shelby (M.D. or other) Crown

Address East Prairie, Mo Date signed 5/7/41

SUPPLEMENTARY

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

MOTHER FATHER

W. J. G.

