

Registration District No. 862

Primary Registration District No. 6135-

1. PLACE OF DEATH:

(a) County. Texas
(b) City or town. Rural Breckenridge
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 68 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas
(c) City or town 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. 0 years.

3. (a) PRINT FULL NAME William Thomas Curry

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

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

7. Birth date of deceased Feb 19 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 1 6 hr. _____ min.

9. Birthplace Texas Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Curry
13. Birthplace Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Charity Jackson
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Racheal Curry
(b) Address Cabool Mo.

17. (a) Burial (b) Date thereof March 26/
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Piggish Cemetery

18. (a) Signature of funeral director _____
(b) Address Cabool Mo.

19. (a) MARCH 26 (MRS. CLOWIE CUNNINGHAM)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Dec 7 1940 to Dec 21 1940

that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to Arteriosclerosis

Other conditions Hypertension
(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) _____

(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 Cabool Mo. Date signed 4/12/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

07
0
0

RECEIVED

District Health Officer No. 5,

District File Number 541614

Date Filed 2120-10-12

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.