

FILED MAR 20 1942 569  
Registration District No.

Primary Registration District No. 5765

Registrar's No.

1. PLACE OF DEATH: Mississippi Wyatt, Mo.  
(a) County Mississippi  
(b) City or town Wyatt, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1 Ohio Sup  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 yrs  
(Specify whether, years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi  
(c) City or town Wyatt, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FERRY CHEW.  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month February day 22  
year 1942 hour 9 minute 0 A. M.  
21. I hereby certify that I attended the deceased from Feb 22  
1942 to Feb 22 1942  
that I last saw him alive on Feb 22  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race Neger  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Callie Chew  
(c) Age of husband or wife if alive 42 years  
7. Birth date of deceased: Jan 10 - 1883  
(Month) (Day) (Year)

Immediate cause of death Mitral Insufficiency  
Duration 10 da.

8. AGE: Years 59 Months 1 Days 12  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 928

9. Birthplace Unknown, Mississippi  
(City, town, or county) (State or foreign country)  
10. Usual occupation Store Keeper & Laborer

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

11. Industry or business \_\_\_\_\_  
12. Name Unknown

13. Birthplace Unknown, M.K.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown, M.K.  
15. Birthplace Unknown, M.K.  
(City, town, or county) (State or foreign country)

16. (a) Informant Callie Chew  
(b) Address Wyatt, Mo.

17. (a) Burial (b) Date thereof 2-25-42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Park Grove

18. (a) Signature of funeral director Travis Shelby  
(b) Address East Prairie, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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?  
(Specify type of place)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Paul Baum (M. D. or other) \_\_\_\_\_  
Address Charlton, Mo. Date signed 2/24/42

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

MOTHER FATHER

745

MAR 18 1942

1401

RECEIVED

District Health Office No. 2,

District File Number 342-423

Date Filed 3-13-42

C.P.P. - 01-24

51-1

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.....

*Travis Shelby*

21 E

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

Registration District No. 569

Primary Registration District No. 5765

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

1. PLACE OF DEATH: Mississippi  
 (a) County W. York  
 (b) City or town \_\_\_\_\_  
 (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 Jerry C Hew  
 3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race B  
 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 Jan 10  
 (Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days \_\_\_\_\_  
 (If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

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

19. (a) Feb 25 1942 (b) Mrs Lou Moore  
 (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 26  
 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration

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

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

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

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?  
\_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M, D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY