

FILED NOV 14 1942

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 97

67
29

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

1. PLACE OF DEATH:

(a) County. MISSISSIPPI

(b) City or town. CHARLESTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
109 DANFORTH ST. 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. 23 YRS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. MISSISSIPPI

(c) City or town. CHARLESTON
(If outside city or town limits, write "RURAL")

(d) Street No. 109 DANFORTH
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country. NONE 0

3. (a) PRINT FULL NAME. JOHN FINLEY LOCKABY

3. (b) If veteran, name war. NO

3. (c) Social Security No. NONE

4. Sex. MALE

5. Color or race. WHITE

6. (a) Single, widowed, married, divorced. SINGLE

6. (b) Name of husband or wife. NONE

6. (c) Age of husband or wife if alive. _____ years

7. Birth date of deceased. SEPTEMBER 13, 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 1 0 _____ hr. _____ min.

9. Birthplace. EDDYVILLE ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation. RETIRED OSTEOPATHIC PHYSICIAN

11. Industry or business. _____

12. Name. JAMES LOCKABY

13. Birthplace. EDDYVILLE ILLINOIS
(City, town, or county) (State or foreign country)

14. Maiden name. SARAH FOWLER

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

16. (a) Informant. OSCAR LOCKABY

(b) Address. DEXTER, MO

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof. 10-14-42
(Month) (Day) (Year)

(c) Place: burial or cremation. LOOF - CHARLESTON, MO

18. (a) Signature of funeral director. [Signature]

(b) Address. CHARLESTON, MO

19. (a) 10/15/42 (Date received by local registrar)

(b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13 year 1942 hour 4:07 minute 17 A. M.

21. I hereby certify that I attended the deceased from Sept. 26 1942 to Oct. 13 1942

that I last saw him alive on Oct 13 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculous Meningitis

Duration 10 days

Due to _____

Due to _____

Other conditions. Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Major findings: Tuberculous meningitis

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. [Signature] (M.D. or other) [Signature]

Address. WYATT, MO Date signed 10-13-42

1257

AUG 10 1947

RECEIVED
District Health Office No. 2,
District File Number 1142-1480
Date Filed 11-3-42

JUN 21 1947

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 John F. Kummel Jr
Licensed Embalmer No. 3851
P.O. Address Charleston W

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.