Dr. Rowland

No. 2
-5-42
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32-73

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 19 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7033

State File No. 7033

Registration District No. 2108

Primary Registration District No. 4538

Registrar's No. 3

1. PLACE OF DEATH:

(a) County: Mississippi

(b) City or town: East Prairie (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether) In this community 5 yrs (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Mississippi

(c) City or town: East Prairie 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: 0

3. (a) PRINT FULL NAME: OLLIE MAYO

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: none

4. Sex: Fem.

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Wesley A. Mayo

6. (c) Age of husband or wife if alive: 45 years

7. Birth date of deceased: Aug. (Month) 5, (Day) 1902 (Year)

8. AGE: Years 41 Months 4 Days 27 If less than one day hr. min.

9. Birthplace: Beth Springs, (City, town, or county) Tenn (State or foreign country)

10. Usual occupation: House wife

11. Industry or business:

MOTHER FATHER

12. Name: J. W. Wilford

13. Birthplace: Beth Springs, (City, town, or county) Tenn (State or foreign country)

14. Maiden name: Addie Pomeroy

15. Birthplace: Decaturville, (City, town, or county) Tenn (State or foreign country)

16. (a) Informant: Wesley A. Mayo

(b) Address: East Prairie, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-2-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Dogwood

18. (a) Signature of funeral director: Travis Shelly

(b) Address: East Prairie

19. (a) 2-6-43 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1 year 1943 hour 1 minute 9 A. M.

21. I hereby certify that I attended the deceased from On 12/26, 1942, to, 19..; that I last saw h. alive on, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Brain Tumor	2 yrs
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: C. Chas Fleming (M. D. or other)

Address: Charleston Mo. Date signed 1/8/43

12-11

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No. 2,
District File Number 243-258
Date Filed 2-16-43

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 James E. Scott, Registered Apprentice No. 316 working under my personal supervision.

Signed Travis Shelly

Licensed Embalmer No. 2726

P. O. Address East Prairie

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
OM—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7033

Registration District No. ____ Primary Registration District No. 4330 Registrar's No. ____

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: East Prairie
(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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Miss.
(c) City or town: East Prairie
(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 ____

3. (a) PRINT FULL NAME: Ollie Mays
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: F
5. Color or race: W
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: Aug (Month) 5 (Day) 1900 (Year)
8. AGE: Years 41 Months 4 Days ____ If less than one day ____ hr. ____ min.
9. Birthplace: Texas (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
FATHER 12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name ____
15. Birthplace ____ (City, town, or county) (State or foreign country)
16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day ____ year 1943 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
Brain tumor	
Due to: Probably malignant	
Due to: was not operated	
Other conditions (Including pregnancy within 3 months of death): Have	
Major findings of operations: post-mortem exam	
Of autopsy: 54 h	

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature: L. Chas. Lewing (M. D. or other)
Address: Charleston, Mo. Date signed ____

SUPPLEMENTARY