

D. A. Martin

21999

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. 27

FILED JUN 1 1943  
Registration District No. 278

Primary Registration District No. 5789

No. 2  
9-4-41  
17-39  
X29484

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

1. PLACE OF DEATH

(a) County: Mississippi

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

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

(d) Length of stay: In hospital or institution: 13 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: Rural  
(If outside city or town limits, write "RURAL")

(d) Street No.: 1 mile South of East Prairie  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: WILLIAM CARSON BIRMINGHAM

3. (b) If veteran, name war: World 3. (c) Social Security No: 497-18-7673

4. Sex: M 5. Color or race: W 6. (a) Single, widowed, married, divorced: Wid

6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: 25 years  
(Day) (Year)

7. Birth date of deceased: May 25  
(Month) (Day) (Year)

8. AGE: Years: 59 Months: 19 Days: \_\_\_\_\_ If less than one day: \_\_\_\_\_ min.

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

10. Usual occupation: Farming

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

12. Name: Unknown

13. Birthplace: Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

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

16. (a) Informant: Mrs Maebell Roberts

(b) Address: East Prairie, Mo

17. (a) Burial, cremation, or removal: burial (b) Date thereof: 5-8-43  
(Month) (Day) (Year)

(c) Place: burial or cremation: W.D.W. Shelby

18. (a) Signature of funeral director: James Shelby

(b) Address: East Prairie

19. (a) 6-19-43 (b) Jamie E. Bugman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 6 year: 1943 hour: 7:20 minute: \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from: April 30th 1943 to: May 6 1943  
that I last saw him alive on: 1 May 4 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Heart disease Duration: \_\_\_\_\_  
Bronchial asthma

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

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

PHYSICIAN: \_\_\_\_\_

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) Means of injury: \_\_\_\_\_

23. Signature: A J Martin (M. D. or other) Address: East Prairie Date signed: 6/8-43

1271

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Office No. 2,  
District File Number 643-839  
Date Filed 6-15-43

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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Travis Shelby*

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 with the above constitutes grounds for revocation of license.)**

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 218

Primary Registration District No. 0789

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm Carson Birmingham

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 25  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ 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) \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

Immediate cause of death Heart disease Duration \_\_\_\_\_  
myocarditis chronic

Due to Bronchial asthma

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

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) \_\_\_\_\_

(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 A J Martin (M. D. or other) \_\_\_\_\_  
Address East Osage Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-21999