

5 AUG 7 1943

Registration District No. Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County *Franklin*

(b) City or town *Union*

(c) Name of hospital or institution: *Found Heart Lab near 33015 Madison*
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State *Miss.* (b) County *Franklin*

(c) City or town *Union* (If outside city or town limits, write "RURAL")

(d) Street No. *1st* (If rural, give location)

(e) Citizen of foreign country? *Not* (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME *Undeclared White Male*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *22*
year *1943* hour *11* minute *40 A.M.*

21. I hereby certify that I attended the deceased from

4. Sex *male* 5. Color or race *White*

6. (a) Single, widowed, married, divorced *Child*

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

7. Birth date of deceased (Month) (Day) (Year) *1943*

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

Immediate cause of death

8. AGE: Years Months Days If less than one day
Adt. *1* hr. min.

Laceration of Brain when found dead on adjacent lot, located at 33015 Madison St. About 11:40 A.M. June 22 1943

Due to

Due to

9. Birthplace (City, town, or county) (State or foreign country) *Union 9*

Other conditions (Include pregnancy within 3 months of death)

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MOTHER FATHER

10. Usual occupation *Unknown*

11. Industry or business *Unknown*

12. Name *Unknown*

13. Birthplace (City, town, or county) (State or foreign country) *Unknown 9*

14. Maiden name *Unknown*

15. Birthplace (City, town, or county) (State or foreign country) *Unknown 9*

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant *Walter Chapman*

(b) Address *1300 Clark*

17. (a) *Antonie's Camp* (b) Date thereof (Month) (Day) (Year) *7-2-43*
(Burial, cremation, or removal)

(c) Place: burial or cremation *St. Louis*

18. (a) Signature of funeral director *W. Richter*

(b) Address *3100 R. St.*

19. (a) *Ill* (b) *J. J. Pender*
(Date received for filing) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *Homicide*

(b) Date of occurrence *Unknown*

(c) Where did injury occur? (City or town) (County) (State) *Unknown*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *Unknown*

While at work? (Specify type of place) (e) Means of injury *Unknown*

23. Signature *Walter Chapman* (M.D. or other)

Address *Unknown* Date signed *6/30/43*

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

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8089

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

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