

S. No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED AUG 12 1943

Registration District No. 217

Primary Registration District No. 5786

Registrar's No. 54

1. PLACE OF DEATH:

(a) County MISSISSIPPI

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

(c) Name of hospital or institution:  
6 MILES EAST  
(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 1 YEAR  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MISSISSIPPI

(c) City or town WYATT - RURAL  
(If outside city or town limits, write "RURAL")

(d) Street No. 6 MI EAST  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country NONE

3. (a) PRINT FULL NAME REBECCA HEAD

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2  
year 1943 hour 9 minute P M.

21. I hereby certify that I attended the deceased from No Medical attendance  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race COLOR

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

6. (b) Name of husband or wife JOHN HEAD

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased SEPTEMBER 5 1894  
(Month) (Day) (Year)

Immediate cause of death Acute Myocarditis

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

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

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

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>10</u>	<u>27</u>	_____ hr. _____ min.

9. Birthplace DARDANELLE, ARKANSAS  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business HOUSEWIFE

12. Name TOM EMBRY

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

14. Maiden name NO RECORD

15. Birthplace NO RECORD 9  
(City, town, or county) (State or foreign country)

Major findings: 93e1

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

16. (a) Informant JOHN HEAD

(b) Address WYATT, Mo Gen Del

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-4-43  
(Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE - CHARLESTON, Mo

18. (a) Signature of funeral director John F. Hummel

(b) Address Charleston Mo

19. (a) Aug 1 - 43 (Date received local registrar) (b) Miss Low Moore (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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury Coroner

23. Signature Miss Shelby (M. D. or other) Coroner

Address Post P.O., Mo Date signed 7/3/43

1251 (Licensed Embalmer's Statement on Reverse Side)

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

67  
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RECEIVED

District Health Office No. 2,

District File Number 848-1011

Date Filed 2-9-43

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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. Kimmel Jr*  
.....  
Licensed Embalmer No. 3851

P. O. Address Charleston, 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.