

FILED DEC 27 1943
128

Registration District No. **128**

Primary Registration District No. **5466**

Registrar's No. **987**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield, S. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MEDICAL CENTER FOR FEDERAL PRISONERS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Months 14 days**
In this community **3 months, 14 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Arkansas** (b) County **Poinsett**
(c) City or town **Marked Tree.**
(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 _____

3. (a) PRINT FULL NAME **WHITE, James**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **U.K.**

4. Sex **male** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **KK** years

7. Birth date of deceased **June 10, 1923**
(Month) (Day) (Year)

8. AGE: Years **21** Months **5** Days **28** If less than one day hr. _____ min.

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

10. Usual occupation **farm work**

11. Industry or business _____

MOTHER FATHER
12. Name **Eddie White**
13. Birthplace **unknown U.S.A.**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown U.S.A.**
(City, town, or county) (State or foreign country)

16. (a) Informant **File**

(b) Address **MCFP**

17. (a) **Removal** (b) Date thereof **12/9/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **12-9-43** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **8**, year **1943** hour **1** minute **27** AM.

21. I hereby certify that I attended the deceased from **August 24, 1943** to **December 8, 1943**; that I last saw him alive on **December 8, 1943**; and that death occurred on the date and hour stated above.

Immediate cause of death **dehydration** Duration **12 days**

Due to **acute psychosis** **12 days**

Due to **dementia praecox, catatonic type.**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **84 P** Of operations _____

Of autopsy **dehydration** PHYSICIAN _____

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 **E. W. Moreland** (M. D. **GENERAL**)
Address **MCFP Executive Officer.** Date signed **12-8-43**

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

39
0
0

984

✓

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. *24 517*

P. O. Address *Waukegan, Ill.*

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.