

FILED MAR 13 1944

Registration District No. 28

Primary Registration District No. 4515

Registrar's No. _____

1. PLACE OF DEATH: *Sullivan*
 (a) County *Milan*
 (b) City or town _____
 (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 _____)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Missouri* (b) County *Sullivan*
 (c) City or town *Milan*
 (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 *James Compton*
 3. (b) Is veteran _____ name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month *Feb*, day *5*, year *1944* hour *6* minute *30* M.

4. Sex *Male* 5. Color or race *White*
 6. (a) Single, widowed, married, divorced *married*
 6. (b) Name of husband or wife *Nancy C. Compton*
 6. (c) Age of husband or wife if alive *80* years
 7. Birth date of deceased *May 17 1854*
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Jan 28* 1944 to *Feb 5* 1944 that I last saw him alive on *Feb 5 5 PM* 1944 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
84 8 18 hr. min.

Immediate cause of death *Chronic Myocarditis* Duration _____

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

Due to *Influenza 6 wks before this*
 Due to *Overexertion following flu*

10. Usual occupation *Retired Farmer*
 11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) *93d*
 Major findings: _____
 Of operations _____
 Of autopsy _____

MOTHER FATHER { 12. Name *David C. Compton*
 13. Birthplace *Kentucky*
 14. Maiden name *Rebecca Grambling*
 15. Birthplace *Sullivan, Mo.*

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

16. (a) Informant *Mrs Lura Chapman*
 (b) Address *Milan Mo.*
 17. (a) *Rural* (b) Date there *Feb 8 1944*
 (Burial, cremation, or funeral) (Month) (Day) (Year)
 (c) Place: burial *Marleyan Milan*
 18. (a) Signature of funeral director *F. D. Schaefer*
 (b) Address *Milan Mo.*
 19. (a) _____ (b) _____
 (Date received local registrar) (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 _____
 Where did injury occur? _____ (City or town) (County) (State)
 (c) 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 *2*
 23. Signature *Dr. L. G. Simmons* (M.D. or other) *D.O.*
 Address *Milan Mo.* Date signed *Feb 4*

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

RECEIVED

District Health Officer No. 10

District File Number 3-44-563

Date Filed MAR 10 1944

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 Frank D. Schoen

Licensed Embalmer No. 2016

P. O. Address Milan, W. Va.

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.

Registration District No. 281

Primary Registration District No. 4515-

Registrar's No. _____

1. PLACE OF DEATH: Sullivan
 (a) County Sullivan
 (b) City or town Milan
 (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 _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME James Compton
 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 M
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 17
 (Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mar 25 1944 (b) Mrs L.D. Green
 (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 _____ or _____
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

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

Major findings:
 Of operations _____
 Of autopsy _____

Duration

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

8553