

Registration District No. 217

Primary Registration District No. 3045

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

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Dr. Office Chapman Building  
(If not in hospital or institution, give street number or location)  
(d) Length of stay: In hospital \_\_\_\_\_ institution \_\_\_\_\_  
In this community All of Life 3 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss. 67  
(c) City or town Henson  
(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 \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Andrew Smith

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

4. Sex M 2 5. Color or race Colored 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased July 8th 1927  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>16</u>	<u>10</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace Henson Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

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

12. Name Clark Crutcher N.K. Tenn  
(City, town, or county) (State or foreign country)

13. Birthplace Monroe Co. Miss. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Render Smith

15. Birthplace Monroe Co. Miss. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Burial

(b) Address Henson, Mo.

(c) Place: burial or cremation Oak Grove Charleston, Mo.

18. (a) Signature of funeral director John F. [Signature]

(b) Address 671/44

19. (a) 6/1/44 (b) Mrs. Lou Moore  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th  
year 1944 hour 10 minute 15P 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 Loss of Blood in Abdominal cavity  
Due to Pistol wound

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 166

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Homicide  
(b) Date of occurrence May 10, 1944  
(c) Where did injury occur? Charleston Miss. Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work no (Specify type of place) Means of injury Coroner  
23. Signature James Shelby (M. D. or other) 3-11-44  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2,

District File Number 644-84

Date Filed 6-14-4

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. Munnell Jr.  
Licensed Embalmer No. 3851  
P. O. Address: Charleston

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.

State File No. July  
Registrar's No. 49

Registration District No. 317 Primary Registration District No. 3045

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Charleston  
(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 Andrew Smith  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced S.  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased: July (Month) 4 (Day) 1944 (Year)

8. AGE: Years 16 Months 10 Days 10 (Unless 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 July year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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 \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Homicide  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? 5-9-44 (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature Haris Shelby (Specify type of place) \_\_\_\_\_ (M. D. or other) Locust  
Address East Prairie Date signed 5-10-44

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

SUPPLEMENTARY

MOTHER FATHER

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

22086