DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 11 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 255207

Registration District No. 2 Primary Registration District No. 5789 Registrar's No. 23

1. PLACE OF DEATH:

(a) County: Mississippi
(b) City or town: Rural St James Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 (Specify whether
In this community: 9 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Mississippi 67
(c) City or town: Rural 0
(If outside city or town limits write "RURAL") 0
(d) Street No.: 7 miles South of E. Prairie,
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: DELMER HALE

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: none

4. Sex: M

5. Color or race: W

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: Oct. (Month) 9, (Day) 1921 (Year)

8. AGE: Years 23 Months 8 Days 24 If less than one day hr. min.

9. Birthplace: Mississippi Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

12. Name: George Hale
13. Birthplace: Mississippi Co. (City, town, or county) Mo. (State or foreign country)
14. Maiden name: Maude Williams
15. Birthplace: Carol (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant: Mrs. Maude Hale
(b) Address: East Prairie, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-4-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Dogwood

18. (a) Signature of funeral director: Travis Shelby
(b) Address: East Prairie Mo

19. (a) 8-4-1944 (Date received by local registrar) (b) Fannie E. Bugman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1944 hour 8 11 minute 30 a. M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Accidental drowned while in swimming

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): Accident 167
(b) Date of occurrence: 7-2-44 Miss. Mo
(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? Public (Specify type of place)
While at work? no (e) Means of injury:

23. Signature: Travis Shelby Coroner (M. D. or other)
Address: East Prairie, Date signed 8-3-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office
District File Number 844-
Date Filed 8-2-

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 Travis Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44 9

Registration District No. 218 Primary Registration District No. 5789 Registrar's No. 231

1. PLACE OF DEATH:

(a) County: Mississippi

(b) City or town: Rural St James Twp

(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME: Delmer Hale

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: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: Oct (Month) 9 (Day) 1921 (Year)

8. AGE: Years 23 Months 8 Days If less than one day hr. min.

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

10. Usual occupation: Farming

11. Industry or business: Farmer

FATHER

12. Name

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

MOTHER

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) Fannie E. Brigman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. year 1944 hour 6 minute 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 — Duration

Due to

Due to

Other conditions (Includes pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

SUPPLEMENTARY

25207