

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:
Green Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Mississippi **67**
 (c) City or town Charleston **1**
(If outside city or town limits, write "RURAL") **2**
 (d) Street No. Green Street
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Margaret McCloud
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month July day 26
 year 1944 hour 12 minute 35 A. M.

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 1, 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-16-44 to 7-20-44
 that I last saw her alive on 7-20-44 and that death occurred on the date and hour stated above.

8. **AGE:** Years 77 Months 3 Days 25
 If less than one day _____ hr. _____ min.

Immediate cause of death apoplexy
Hypertensive Heart Disease
 Duration 1 wk.

9. Birthplace (Unknown) Alabama
(City, town, or county) (State or foreign country)

Due to _____
 Due to _____

10. Usual occupation Housewife

Other conditions 93d
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER, FATHER
 12. Name Dan Moore
 13. Birthplace (Unknown) Alabama
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Drish
 15. Birthplace (Unknown) Alabama
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
93d

16. (a) Informant Albert Mallory (Son)
 (b) Address 604 Cypress St., Charleston, Mo.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof July 30, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Oak Grove Cemetery

While at work? _____
(Specify type of place) (e) Means of injury _____

18. (a) Signature of funeral director F. J. Spartz
 (b) Address Cape Girardeau, Mo.

23. Signature W. A. Fingal (M. D. or other) _____
 Address 204 S. Locust St. Charleston, Mo. 7-2844

19. (a) Not received local registrar (b) Mrs. L. Moore
(Registrar's signature)

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

87
1
2

RECEIVED

District Health Office No. 2

District File Number 844-1064

Date Filed 8-9-44

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 Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau, Mo.

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

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