

FILED SEP 18 1944

Primary Registration District No. **3045**

Registrar's No. **64**

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

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: **517 Olive St.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Octavia Lott**

3. (b) If veteran, name war: -----

3. (c) Social Security No. -----

4. Sex **Female** 5. Color or race **3 Negro**

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: **January 10, 1884**
(Month) (Day) (Year)

8. AGE: Years **60** Months **7** Days **5** If less than one day hr. min.

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

10. Usual occupation **Domestic**

11. Industry or business: -----

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ivy Parker**

(b) Address **517 Olive St.**

17. (a) **Burial** (b) Date thereof **Aug. 20, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **F. J. Sparks**

(b) Address **Capo Girardeau, Mo.**

19. (a) **9/1/44** (b) **Missouri**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mississippi**

(c) City or town **Charleston**
(If outside city or town limits, write "RURAL")

(d) Street No. **517 Olive St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country: -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **15**
year **1944** hour **12:00 noon** minute M.

21. I hereby certify that I attended the deceased from **8-12-1944** to **1944**;
that I last saw **her** alive on **8-12-1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** **6 days**

Due to **Chronic Nephritis** **12 months**

Due to -----

Other conditions (include pregnancy within 3 months of death) **1312**

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 **W. A. Singal** (M, D, or other) -----
Address **204 S. Decatur St. Charleston, Mo.**

RECEIVED

District Health Office No. 2,

District File Number 944-1213

Date Filed 9-8-44

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 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.