

FILED SEP 13 1944

Registration District No. 240

Primary Registration District No. 5826

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

1. PLACE OF DEATH:

(a) County New Madrid Co. Mo.
(b) City or town Paris, Mo.
(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 21 years. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. near Corran, Missouri (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Robert Corran

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex M

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased unknown 1889
(Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Charleston, Miss
(City, town or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Joe Corran

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

14. Maiden name May Hanna
(City, town, or county) (State or foreign country)

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

16. (a) Informant Joe Hill

(b) Address Corran, Mo.

17. (a) Burial (b) Date thereof Aug. 26, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jay West cemetery

18. (a) Signature of funeral director J. W. ...

(b) Address _____

19. (a) 9-1-44 (b) Mrs. J. L. Parrett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25 year 1944 hour 8 minute P 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: No medical attendance by all records death was due to Pulmonary Tuberculosis
Due to _____
Due to _____

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

Major findings: 1361
Of operations _____

Of autopsy _____

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? _____

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

23. Signature Leo Hedgcock (M.D. or other) _____

Address New Madrid Date signed 9-29-44

RECEIVED

District Health Office No. 2,

District File Number 944-1258

Date Filed 9-12-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.