

FILED OCT 19 1944

Registration District No. _____

Primary Registration District No. **5786**

1. PLACE OF DEATH:

(a) County **Mississippi**
 (b) City or town **R#3 Charleston** (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Box 57---Residence-rural
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **2 months in County** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Matilda Smith**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **NO**

4. Sex **Female** 5. Color or race **Color**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **John Henry Smith** 6. (c) Age of husband or wife if alive **36** years
 7. Birth date of deceased **September 17th, 1907**
 (Month) (Day) (Year)

8. AGE: Years **36** Months **10** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Rena Lara Mississippi**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **at home**

MOTHER FATHER { 12. Name **Ike Ruffin**
 13. Birthplace **Rena Lara, Mississippi**
 14. Maiden name **Alma Simmons**
 15. Birthplace **Kingston N. Car.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Christy Ruffin**
 (b) Address **R#1 Box 89, Cairo, Ill**
 17. (a) **Burial** (b) Date thereof **7/30/44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Thistlewood-Mounds, Ill**
 18. (a) Signature of funeral director **Ruffin Funeral Home**
 (b) Address **Cairo, Ill**

19. (a) **10/1/44** (b) **Mrs. Lon Moore**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Alexander**
 (c) City or town **Cairo-rural** (If outside city or town limits, write "RURAL")
 (d) Street No. **R#1 Box 89** (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **27th**
 year **1944** hour **7** minute **35 P.M.**

21. I hereby certify that I attended the deceased from **May 20, 1944** to **July 27, 1944**
 that I last saw her alive on **July 23, 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of liver** 5 mo

Due to _____
 Due to **46%**
 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) _____
 (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)
 (c) Means of injury **2**
 23. Signature **W. P. Fenton** (M. D. or other)
 Address **Wyatt, Mo.** Date signed **7-28-44**

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

RECEIVED

District Health Office No. 2,

District File Number 044-1419

Date Filed 10-18-44

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.

*Embalmed in Illinois
by Licensed Embalmer
Edward W. Ruffin* 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.

Registration District No. 217

Primary Registration District No. 5786

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

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Paul Ohio Camp
(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

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

Matilda Smith

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race Colo

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 17 1901
(Month) (Day) (Year)

8. AGE:

Years 36 Months 10 Days 10
If less than one day, hr. _____ min. _____

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

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 from registrar)

(b)

Mrs. L. M. ...
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 17 Year _____

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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____

(Include 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____

(M. D. or other)

Address _____ Date signed _____

