

FILED NOV 22 1944

Registration District No. **47**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH
 (a) County Callaway
 (b) City or town Freson
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hosp #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9-22-44
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Joe White
 3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 63 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace ms (City, town, or county) _____ (State or foreign country) D

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name John White
 13. Birthplace ms (City, town, or county) _____ (State or foreign country) _____
 14. Maiden name _____
 15. Birthplace ms (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant he card
 (b) Address _____

17. (a) Removal (b) Date thereof 10-2-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 10-2-1944 (b) Joe Morant
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State ms (b) County Andrain
 (c) City or town Mexico 14
(If outside city or town limits, write "RURAL") 1
 (d) Street No. _____ (If rural, give location) 2
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 2nd
 year 1944 hour 4 minute 15 a. M.
 21. I hereby certify that I attended the deceased from 11-30- 1943 to 10-2- 1944
 that I last saw him alive on 10 / 1 1944
 and that death occurred on the date and hour stated above.
 Immediate cause of death hypertension

Due to _____

Due to 309

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)

(e) Means of injury _____

23. Signature K E Sherrill (M. D. or other) _____

Address 51 Nelson rd Date signed 10/2/44

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 11-17-44

STATEMENT BY LICENSED EMBALMER

will be

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

Stuart D. Parker

Licensed Embalmer No. 3900

P. O. Address Columbia 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.