

Registration District No. 270

Primary Registration District No. 3050

1. PLACE OF DEATH:
 (a) County Remick
 (b) City or town Caruthersville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
None
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Neil Wilbourn Sr.
 3. (b) If veteran, no.
 3. (c) Social Security name war. _____ No. _____

4. Sex M 5. Color or race Cal.
 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 _____ (Month) (Day) (Year) 1860

8. AGE: alt 84 Years Months Days If less than one day
 hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER
 12. Name D.K.
 13. Birthplace D.K.
(City, town, or county) (State or foreign country)
 14. Maiden name D.K.
 15. Birthplace D.K.
(City, town, or county) (State or foreign country)

16. (a) Informant Neil Wilbourn Jr.

(b) Address Caruthersville Mo. 406 Cotton

17. (a) Burial (b) Date thereof 10-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caruthersville Mo

18. (a) Signature of funeral director German Funeral Home

(b) Address St. Louis Mo

19. (a) 12-27-1944 (b) Jessie W. Markay
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Remick 73
 (c) City or town Caruthersville
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
 year 1944 hour 6:00 minute _____ M.

21. I hereby certify that I attended the deceased from Oct 17 1944 to Oct 21 1944
 that I last saw him alive on Oct 21 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death severely nephritis
severely

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? _____

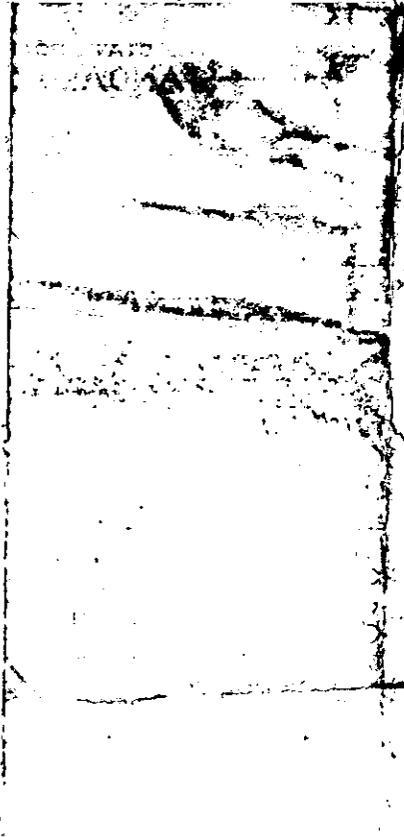
While at work? _____ (Specify type of place) (b) Means of injury 2

23. Signature Dr. J. B. Dutew (M. D. or other)

Address Caruthersville Mo. Date signed Oct 22 44

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

12-44-286



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 *Johnell German*.....
Licensed Embalmer No. *4255*.....

P. O. Address *Steele, Mo. Bx 3*.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 127

Registration District No. 270

Primary Registration District No. 3060

1. PLACE OF DEATH:
(a) County Pemissit
(b) City or town Courthouseville
(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)

3. (a) PRINT FULL NAME Neil Wilbourn Jr
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced S
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 84 Months _____ Days _____ (Unless than one day)
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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ give on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Chronic nephritis
Arterio Sclerosis
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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 J.B. Kuten (M. D. or other) _____
Address Courthouseville Mo. Date signed 1-10-44

SUPPLEMENTARY

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

S-41808 1944