

**FILED** SEP 7 1945

27980

State File No.

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 61

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:  
South Elm St.  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss. 67

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

(d) Street No. South Elm St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country None

3. (a) PRINT FULL NAME Tom White

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6th  
year 1945 hour 2 minute 30P M.

4. Sex M 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 9 years

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

21. I hereby certify that I attended the deceased from Dec 10<sup>th</sup> 1944 to June 6<sup>th</sup> 1945  
that I last saw him alive on June 5<sup>th</sup> 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

About 80 hr. min.

Immediate cause of death Mitral Insufficiency

Due to Chronic Nephritis

Due to Hypertension

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace N.K. (City, town, or county) (State or foreign country) 9

10. Usual occupation Day Laborer

Major findings: Of operations 131W

Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

11. Industry or business

MOTHER FATHER { 12. Name N.K.

{ 13. Birthplace N.K. (City, town, or county) (State or foreign country) 9

{ 14. Maiden name N.K.

{ 15. Birthplace N.K. (City, town, or county) (State or foreign country) 9

16. (a) Informant Public

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Charleston, Mo.

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?

18. (a) Signature of funeral director John F. Nemele

(b) Address 711/45 E. Charleston, Mo.

19. (a) W. L. H. S. (Data received local registrar) (b) W. L. H. S. (Registrar's signature)

While at work at home (Specify type of place) (c) Means of injury ---

23. Signature Frank S. Vernon (M. D. or other) 0

Address Charleston, Mo. Date signed 6-7-45

1257

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No.

District File Number 9-5-2

Date Filed 9-5-4

**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.

not Embalmed

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept 61  
Registrar's No. \_\_\_\_\_

Registration District No. 217

Primary Registration District No. 3045

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston  
(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

Tom White

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 Mr. data

6. (b) Name of husband or wife (no data) 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

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 \_\_\_\_\_ Year 1945 \_\_\_\_\_ (month) \_\_\_\_\_ (day) \_\_\_\_\_ (hour) \_\_\_\_\_ (minute) \_\_\_\_\_ (M.)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

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

SUPPLEMENTARY

S-27980