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43
-17-39
X38671

FILED OCT 11 1945

Registration District No. **107**

Primary Registration District No. **3019**

Registrar's No. **3**

1. PLACE OF DEATH:
(a) County **Dunklin**
(b) City or town **Kennett Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Presnell Hospital
(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 **78**
(c) City or town _____ (If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No) **1**
If yes, name country _____

3. (a) PRINT FULL NAME **Baby. Nannery NUNNELY**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **8** day **30**
year **1945** hour **2** minute **30 p** M.
21. I hereby certify that I attended the deceased from
8-30 19**45** to **8-30** 19**45**
that I last saw him alive on **8-30** 19**45**
and that death occurred on the date and hour stated above.

4. Sex **F** **5. Color or race** **W**
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if**
alive _____ years
7. Birth date of deceased **8-30-45**
(Month) (Day) (Year)

Immediate cause of death **monstrous**
(Anencephalic)
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years _____ Months _____ Days _____ If less than one day
1 hr. **1** min.

9. Birthplace **Kennett Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Dorris Lee Nannery NUNNELY**
13. Birthplace **Dk Tenn**
(City, town, or county) (State or foreign country)

14. Maiden name **Lucelle Heath**
15. Birthplace **Lauderllo Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward Heath**
(b) Address **Bragg City Mo**

17. (a) Burial **(b) Date thereof** **8 30-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Ridge Cem**

18. (a) Signature of funeral director **Lentz Und Co**
(b) Address **Kennett Mo**

19. (a) 9-2-45 **(b) Carl Hubbard**
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations **17c**
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? _____

23. Signature **G. G. Wilson** (M. D. or other) **MD**
Address **Kennett, Mo** **Date signed** **8-31-45**

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

MOTHER FATHER

1548

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2

District File Number 1045-31

Date filed 1-5-8-4

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.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 0cp
Registrar's No. 3

Registration District No. 107

Primary Registration District No. 3019

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

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Kennett
(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 Mo (b) County Dunklin
(c) City or town Drugg City Rural
(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 Infant Murrely
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F 5. Color or race w
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____
7. Birth date of deceased aug 30
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ 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)

(b) 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 _____

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

Address _____ Date signed _____

SUPPLEMENTARY

30479