

FILED *M.E. Mills*
8 1945

State File No.

Registration District No. *333*

Primary Registration District No. *3074*

Registrar's No. *6*

1. PLACE OF DEATH:

(a) County *Sevier, mo*
(b) City or town *Sevier, mo*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: *1*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community *Life*
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Sevier 100*
(c) City or town *Sevier mo 5*
(If outside city or town limits, write "RURAL")
(d) Street No. *215 Trotter Sevier, mo 2*
(If rural, give location)
(e) Citizen of foreign country? *No.* (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Charles Dewain Hazel*

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

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *0*
6. (b) Name of husband or wife *-* 6. (c) Age of husband or wife if alive years *13* 1945 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - 6 hr. min.

9. Birthplace *Sevier mo* (City, town, or county) (State or foreign country)

10. Usual occupation *-*

11. Industry or business *-*

MOTHER FATHER { 12. Name *Charley Hazel*
13. Birthplace *Sevier Co mo* (City, town, or county) (State or foreign country)
14. Maiden name *ORA RAINES*
15. Birthplace *Ill.* (City, town, or county) (State or foreign country)

16. (a) Informant *Charley Hazel*

(b) Address *215 Trotter St Sevier, mo*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *8-20-45* (Month) (Day) (Year)

(c) Place: burial or cremation *Sevier, mo*

18. (a) Signature of funeral director *John Alton*

(b) Address *Sevier, mo*

19. (a) *9/25/45* (Date received local registrar) (b) *Mrs F. Henry* (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *8* day *19* year *1945* hour *11:00* minute *11* A. M.

21. I hereby certify that I attended the deceased from *8/13/45*, 19____, to *9/19/45*, 19____; that I last saw *1* alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death *Premature Child.*

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations *159*

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 *2 DO*

23. Signature *McNeil* (M. D. or other)

Address *Sevier mo* Date signed *9/21/45*

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

RECEIVED

District Health Office No. 2,

District File Number 1045-3075

Date Filed 10-1-48

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.....

Not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed..... Hunter Whitton

Licensed Embalmer No. 4210

P. O. Address..... Sikeston, 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.