

**FILED** APR 16 1946

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 25

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:  
Greenwood St., 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 All of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi 67  
(c) City or town Charleston  
(If outside city or town limits, write "RURAL")  
(d) Street No. SoGreen St  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

3. (a) PRINT FULL NAME Azalee Pettigrew  
3. (b) If veteran, name war none 3. (c) Social Security No. none  
4. Sex Female 5. 3 negro race Color 6. (a) Single, widowed, married, 2 divorced, Widowed  
6. (b) Name of husband or wife Thos. Pettigrew 6. (c) Age of husband or wife if alive deceased years  
7. Birth date of deceased 1/17/1882  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month February day 12th  
year 1946 hour 11 minute P M.  
21. I hereby certify that I attended the deceased from 10-7-45  
1946 to 2-18- 1946  
that I last saw her alive on 2-18- 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 64 Months 0 Days 25 If less than one day  
hr. \_\_\_\_\_ min.

Immediate cause of death Memie Leukemia  
Due to Chronic Nephritis  
Duration 4 mon.  
6 mon.

9. Birthplace Belmont Missouri  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation At home  
11. Industry or business Housewife

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 131/1  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
12. Name Howard Underwood  
13. Birthplace Dont know 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Dont know  
15. Birthplace Dont know 1 9  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Thomas Pettigrew  
(b) Address Charleston, Mo  
17. (a) Burial (b) Date thereof 2/17/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove - Charleston, Mo

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. A. Fernald (M. D. or other)  
Address 504 S. Locust - Charleston, Mo Date signed 2-23-46

18. (a) Signature of funeral director John F. Fernald  
(b) Address Charleston, Mo  
19. (a) 3-6-46 (b) Mrs. John Boardman  
(Date received local registrar) (Registrar's signature)

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RECEIVED  
District Health Off  
District File Number 44  
Date Filed 4-4-4

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**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

*John F. Munnick Jr.*

Licensed Embalmer No.

*3851*

P. O. Address

*Charleston*

**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.**

**FILED** APR 17 1944 **STANDARD CERTIFICATE OF DEATH**

Registration District No. 217

Primary Registration District No. 3045

State File No. April

Registrar's No. 25-

**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:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days

**3. (a) PRINT FULL NAME** Gale Pettigrew  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race negro 6. (a) Single, widowed, married, divorced wid  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: Jan 17 1903  
 (Month) (Day) (Year)

8. AGE: Years 64 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 \_\_\_\_\_

**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)

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

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs. John R. ... (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 April year 1946 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 \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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 \_\_\_\_\_

Signature \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY 2**

10147