

FILED **10 1946** **STANDARD CERTIFICATE OF DEATH**

State File No. **17429**

Registration District No. **217**

Primary Registration District No. **3045-5787**

Registrar's No. **49**

1. PLACE OF DEATH:
 (a) County **Mississippi**
 (b) City or town **Charleston, Rural**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Route #2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **20 years**
(Specify whether years, months or days)
 In this community **20 years**

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

3. (a) PRINT FULL NAME **Alice Holmes**
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Female** 5. Color of race **Negro Col** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Charlie** (c) Age of husband or wife if alive **4** years **1882**
 7. Birth date of deceased **June 4 1882**
(Month) (Day) (Year)

8. AGE: Years **63** Months **10** Days **16** If less than one day hr. min.

9. Birthplace **Shelby Co., TN** **Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**

11. Industry or business.....

MOTHER FATHER
 { 12. Name **Isaac Bethel**
 { 13. Birthplace **Georgia**
(City, town, or county) (State or foreign country)
 { 14. Maiden name **Sally**
 { 15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary White Bird**

(b) Address **R#2, Box 182, Charleston, Mo**

17. (a) **Burial** (b) Date thereof **Apr. 23, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Cemetery**

18. (a) Signature of funeral director **John F. Hummel**

(b) Address **Charleston, Mo**

19. (a) **5-18-46** (b) **Mrs. J. P. Bordenant**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **20**
 year **1946** hour **1:00** minute **P** M.

21. I hereby certify that I attended the deceased from **April 19**, 19**46**, to **April 20**, 19**46**
 that I last saw **her** alive on **April 19**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation** **3 wks**
 Duration

Due to **Hypertension and coronary atherosclerosis** **5 years**

Due to.....
 Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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?
(Specify type of place)

While at work?..... (e) Means of injury **0**

23. Signature **William J. Davis** (M. D. or other) **M.D.**

Address **Charleston, Mo** Date signed **Apr. 23, 1946**

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

RECEIVED
District Health Office No. 2,
District File Number 646-701
Date Filed 6-6-46

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. Munnell Jr
Licensed Embalmer No. 3851

P. O. Address Charleston, W.

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. June
Registrar's No. 49

Registration District No. 217

Primary Registration District No. 6787

1. PLACE OF DEATH:

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

Abiel Helmer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race B

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 June 7
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days _____ (Unless 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 _____
(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)

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 June
year 1960 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial insufficiency
Duration _____

Due to Coronary arteriosclerosis
Due to _____

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

Major findings:
Of operations _____

Of autopsy 97

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

6370

17429