

FILED FEB 19 1947

Registration District No. **108**

Primary Registration District No. **4179**

Registrar's No. **7**

1. PLACE OF DEATH:

(a) County **Burke**
(b) City or town **Susath 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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Burke**
(c) City or town **Susath**
(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 JAMES A. FOLLOWELL

(b) If veteran, name war **WT** (c) Social Security No. **400**

4. Sex **Male** 5. Color or race **White** 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 **Aug 22, 1868**
(Month) (Day) (Year)

8. AGE: Years **79** Months **5** Days **16** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Coal Milling**

11. Industry or business _____

12. Name **Bob Followell**

13. Birthplace **unk**
(City, town, or county) (State or foreign country)

14. Maiden name **Emma Wenger**

15. Birthplace **Gill**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Followell**

(b) Address **Susath, Mo.**

17. (a) _____ (b) Date thereof **2-9-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Yague Cemetery**

18. (a) Signature of funeral director **Emery**

(b) Address **Jarvisburg Ark.**

19. (a) **2-12-1947** (b) **Mrs J. H. Daniel**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **8** year **1947** hour **4** minute **30 PM**

21. I hereby certify that I attended the deceased from **Nov 12, 1946** to **Feb 8, 1947**
that I last saw him alive on **Nov 22, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Streptococcus pyogenes**
of throat
Due to **with secondary meningitis**

Due to _____
Other conditions **General debility**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **150**

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 **D**
23. Signature **Roy G. Bessel** (M. D. or other) **MD**
Address **Susath Mo.** Date signed **2-9-47**

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

91

MAR 25 1947

RECEIVED

District Health Office No. 2,

District File Number 247-248

Date Filed 2-17-47

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.

Registration District No. 108

Primary Registration District No. 4179

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(a) County Dunklin
(b) City or town Senath
(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 _____ (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 _____

3. (a) PRINT FULL NAME

James A. Fellowship

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 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 22 (Month) (Day) (Year)

8. AGE: Years 79 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)

(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 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him _____ 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)

Major findings: Of operations _____

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 _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-4468