

S. No. 2
M-5-43
5-17-39
P I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37598**

FILED DEC 3 1947
Registration District No. **707**

Primary Registration District No. **5422**

Registrar's No. **256**

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

1. PLACE OF DEATH:

(a) County DUNKLIN

(b) City or town KENNETT - RURAL Ind.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community Life time
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County DUNKLIN **350**

(c) City or town KENNETT RURAL #2
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME ALLEN CORNELIUS CONGILL

3. (b) If veteran, name war _____ 3. (c) Social Security No. 355-22-9427

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 15 year 1947 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JAN. 10 1919
(Month) (Day) (Year)

Immediate cause of death Acute Heart Failure Duration _____

Due to Chronic Heart Disease

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>28</u>	<u>10</u>	<u>5</u>	hr. _____ min. _____

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

Major findings: Of operations _____

Of autopsy _____

9. Birthplace BLYTAEVILLE ARK. 1
(City, town, or county) (State or foreign country)

10. Usual occupation FAKER

11. Industry or business FARMING

12. Name T.A. CONGILL

13. Birthplace CRAIGHEAD Co. ARK. 1
(City, town, or county) (State or foreign country)

14. Maiden name HEATH

15. Birthplace TENN 1
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant T.A. CONGILL

(b) Address KENNETT, MO. R.# 2

17. (a) BURIAL (b) Date thereof 11 16 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KENNETT

18. (a) Signature of funeral director Walter Russell

(b) Address Kenett, Ark.

19. (a) 11-16-47 (b) Walter Russell
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury 3

23. Signature Walter G. Haubert Coroner
Address Kenett, MO Date signed 11-16-1947

RECEIVED

District Health Office No. 2,

District File Number 1247-1520

Date Filed 12-1-47

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.