

No. 2
5-43
5-17-39
K36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32429**

FILED OCT 21 1948

Registration District No. **2**

Primary Registration District No. **474**

Registrar's No. **15**

1. PLACE OF DEATH:

(a) County **COOPER**

(b) City or town **PRAIRIE HOME**
(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 **22 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER?**

(c) City or town **PRAIRIE HOME?**
(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 _____

3. (a) **PRINT FULL NAME** **WYSSSES G. SOUTHERLAND**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month **10** day **14**
year **1948** hour **3** minute **15** A.M.

21. I hereby certify that I attended the deceased from **10-1-48** to _____, 19____
that I last saw him alive on **10-10-48**, 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 **1 MARRIED**

6. (b) Name of husband or wife **EDNA**

6. (c) Age of husband or wife if alive **69** years
3 - 1865 (Month) (Day) (Year)

7. Birth date of deceased.

Immediate cause of death **Chronic Bronchitis**

Duration **54**

8. AGE:

Years	Months	Days	If less than one day
83	4	11	hr. _____ min. _____

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

10. Usual occupation **MERCHANT**

11. Industry or business _____

MOTHER FATHER

12. Name **Wm SOUTHERLAND**

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

14. Maiden name **NANCY BOTTOM**

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

16. (a) Informant **Edna Southerland**

(b) Address **Prairie Home Mo**

17. (a) **BURIAL** (b) Date thereof **10-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WALNUT GROVE CEM.**

18. (a) Signature of funeral director **C. ALBERT HORNBECK**

(b) Address **PRAIRIE HOME MO**

19. (a) **10-18-48** (b) **A. J. Meredith**
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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

Major findings: **1370**

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 **W. R. Meredith** (M. D. or other) _____

Address **Prairie Home Mo** Date signed **10/15/48**

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

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 *C. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Prairie Home 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *now*Registration District No. *83*Primary Registration District No. *4143*Registrar's No. *15-*

1. PLACE OF DEATH:

- (a) County *Cooper*
 (b) City or town *Prairie Home*
 (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)3. (a) PRINT FULL NAME *Wlysses Southland*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex
- M*
- 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 _____ years

7. Birth date of deceased
- June 3 1901*
-
- (Month) (Day) (Year)

8. AGE: Years
- 83*
- Months _____ Days _____ If less than one day
-
- hr. _____ min. _____

9. Birthplace
- Mo*
-
- (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) *10-19-1944* (b) *Dr. A. L. Meredith*
 (Date received by 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 _____ Day _____
-
- Year
- 1944*
- hour _____ minute _____ M.
- 14*

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 _____

Duration

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

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
- Dr. A. L. Meredith*
- (M. D. or other)
- M.D.*
-
- Address
- Prairie Home*
- Date signed
- 10-19-44*

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

SUPPLEMENTARY

S-32429