

1. PLACE OF DEATH:

(a) County ~~Missouri~~ Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Sikeston General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 6 hrs
(Specify whether
In this community. 6 hours
years, months or days)

3. (a) PRINT FULL NAME Benjamin Franklin Terrell

3. (b) If veteran, name war World War I
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 13 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 3 28 hr. min.

9. Birthplace Ballard County, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Disabled War Veteran

11. Industry or business None

12. Name Charles N. Terrell

13. Birthplace Blandville, Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Wells

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

16. (a) Informant Mr. W. D. Terrell

(b) Address RFD., Wyatt, Missouri.

17. (a) Burial (b) Date thereof 11-14-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Charleston, Mo.

18. (a) Signature of funeral director Joe R. Nimmeler

(b) Address Charleston, Missouri

19. (a) 11-18-48 (b) Mrs. D. F. Henry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Wyatt, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 4 miles SW of Wyatt,
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11th
year 1948 hour 6:00 minute 20 A.M.

21. I hereby certify that I attended the deceased from 11-11-48
19 to 11-11-48 19
that I last saw him alive on 11-11-48 19
and that death occurred on the date and hour stated above.

Immediate cause of death
cerebral hemorrhage

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 E. D. Nolan (M. D. or other) M.D.

Address Sikeston, MO Date signed 11-15-48

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

7961 S MAR

RECEIVED

District Health Office No. 2

District File Number 11-4-155-2

Date Filed 11-19-48

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 Joe R. Nunnelee

Licensed Embalmer No. 4413

P. O. Address Charleston, 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.