

No. 2
-12-45
5-17-39
X47070

FILED JAN 13 1949

Registration District No. **217**

Primary Registration District No. **3045**

1. PLACE OF DEATH:

(a) County **Mississippi**

(b) City or town **Charleston**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
404 W. Cypress St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **5 years** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **George Bobo**

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. **320-20-8756**

4. Sex **Male** 5. Color or race **Negro**

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 **Unknown 1888**
(Month) (Day) (Year)

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

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

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER

12. Name **Frank Bobo**

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

14. Maiden name **Bettie Booker**

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

16. (a) Informant **Willie Hurt**

(b) Address **1300 W. St. Joe St., Lansing, Mo.**

17. (a) **Burial** (b) Date thereof **Dec. 24, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **F. J. Sparks**

(b) Address **Charleston Mo.**

19. (a) **1-5-49** (b) **Mrs. John Bonduca**
(Date received local registrar) (Registrar's signature) 19**46**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mississippi**

(c) City or town **Charleston**
(If outside city or town limits, write "RURAL")

(d) Street No. **404 W. Cypress St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **22**
year **1948** hour **10:** minute **30P.** M.

21. I hereby certify that I attended the deceased from **on Dec 20 1948** to **19 48**
that I last saw him alive on **Dec 20** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Ventricular Fibrill**

Due to **Valvular Endocarditis**

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **none**

Of autopsy **none 92**

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)

Means of injury **0**

23. Signature **F. J. Sparks** (M. D. or other)

Address **Charleston Mo.** Date signed **1/3/49**

Duration **D.K.**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2,

District File Number 149-64

Date Filed 1-11-49

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 Frank Smith
Licensed Embalmer No. 3450
P. O. Address Cape Girardeau, 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.