

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007709

STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 32

FILED MAR 15 1963

DO NOT WRITE ON THIS STUB  
 AMENDED

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
1 0675				
2 06752				
3				
4 2				
5 2				
6				
7 9				
8 0				
9 7954				
10				
11				
12 90-8				
13 1-0				
	ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Miss.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>		Length of stay in 1b <b>40 Yrs.</b>	c. CITY OR TOWN <b>Charleston</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <b>None</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>618 So. Locust St.</b> Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sherwood Thomas</b>			4. DATE OF DEATH Month Day Year <b>3, 1, 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>70</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE		17. INFORMANT Address <b>Maud McGee 409 W. Cypress St.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Presumed to be natural causes</b> DUE TO (b) <b>Coroner of Miss. Co. notified</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dorothy B. Hathorn Registrar</b>		22b. ADDRESS <b>Charleston Mo</b>	22c. DATE SIGNED <b>3-9-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/9/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Charleston Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Dorin Charleston Mo</b>		25. DATE RECD. BY LOCAL REG. <b>3-9-63</b>	26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hathorn</b>

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH

*Permit issued*  
*3/26/53*  
*SK*

**STATEMENT BY LICENSED EMBALMER**

8-08

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Willie R. Davis

Licensed Embalmer No. 0729

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.