

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

40279  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Mississippi Registration District No. 5760  
 (b) Township Ohio Primary Registration District No. 5762  
 (c) City Wyatt (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 650 Augusta Green Jr.

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Color 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 2, 1938

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>1</u>	<u>9</u>	<u>14</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant

9. Industry or business in which work was done, as saw mill, bank, etc. Infant

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Wyatt, Mo (STATE OR COUNTRY)

FATHER

13. NAME Guss Green

14. BIRTHPLACE (CITY OR TOWN) Gunnison, Miss (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Chatherin Ralston,

16. BIRTHPLACE (CITY OR TOWN) Caruthersville, Mo (STATE OR COUNTRY)

17. INFORMANT Guss Green, (ADDRESS) Wyatt, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cem DATE 11/17/1939

19. FUNERAL DIRECTOR (NAME) Lair-Nunnelee (ADDRESS) Charleston, Mo

20. FILED 11-18- 1939 F. J. Vernon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/16/39 1939

22. I HEREBY CERTIFY, That I attended deceased from View 19 to 19, 1939  
 I last saw h. View alive on 19, 1939 Death is said to have occurred on the date stated above, at 10:30a  
 The principal cause of death and related causes of importance were as follows:  
This baby died on the way to a doctors office when taking the bath. Plus colic + convulsions did not have a doctor  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 11/16

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis History/History Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 1939  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased no  
 If so, specify \_\_\_\_\_  
 (Signed) Frank S. Vernon M. D.  
 (Address) Charleston Mo

RECEIVED

District Health Officer No. 2

District File Number

1239-370

Date Filed

12-1

**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, above space should be left blank.