

FILED MAR 5 - 1940

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

Do not use this space.

1. PLACE OF DEATH

County *De Kalb* Registration District No. *258*  
Township *Washington* Primary Registration District No. *5360*  
City *Clarksdale, Miss.*

File No. *6451*  
Registered No. *3*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Clamon Jerome Babbitt*  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) \_\_\_\_\_ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Harriet Babbitt*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *12-28-1869*

7. AGE YEARS *71* MONTHS *10* DAYS *9* IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*

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

10. Date deceased last worked at this occupation (month and year) *1940* 11. Total time (years) spent in this occupation *45*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

13. NAME *Jerome Babbitt*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*

15. MAIDEN NAME *Mary Pettie*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

17. INFORMANT (ADDRESS) *Mrs. Clayton Babbitt, Clarksdale, Miss.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Pleasant Grove* DATE *2-7-1940*

19. UNDERTAKER (ADDRESS) *John Brann, Clarksdale, Miss.*

20. FILED *Feb 9, 1940* *Mrs. C. M. Davis* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2/6*, 19*40*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 1st*, 19*40*, to *Feb 3rd*, 19*40*

I last saw him alive on *Feb 3rd*, 19*40* Death is said

to have occurred on the date stated above, at *H. A. M.*

The principal cause of death and related causes of importance were as follows:

*myocardial degeneration* Date of onset *3/29/39*

Other contributory causes of importance: *Bradycardia*

Name of operation *none* Date of \_\_\_\_\_

What test confirmed diagnosis? *Chis* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

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) *O. F. Parham* M. D.

*9:33* (Address) *Clarksdale, Miss.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

RECEIVED  
District Health Officer No. 111  
District File Number  
Date Filed

RECEIVED

District Health Officer No. 111

District File Number 340-197

Date Filed MAR 1 1940

1940  
MAR 1  
1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **6457**

Registration District No. **258**

Primary Registration District No. **5360**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **DeKalb**  
(b) City or town **Washington** **Tenn**  
(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 **Almon Jerome Babbitt**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased **12 28 1866**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **1** Days **8** If less than one day..... hr. min.

9. Birthplace..... (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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **2/19 1940** (b) **Mrs C. M. Davis**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **De Kalb**

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

(d) Street No. **3 mi NE of Clarkedale**  
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **6**  
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

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 **D. L. Perkins** (M. D. or other).....

Address **Clarkedale, Tenn**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

