

FILED APR 8 1940

Registration District No. 576

Primary Registration District No. 5765

Registrar's No. 33

69

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Henson (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 3 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ruthey Calvert

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

3. (c) Social Security No. X X X

4. Sex Female

5. Color or race Col.

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Jim Calvert

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased X X 1923
(Month) (Day) (Year)

8. AGE: Years 17 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Blythville Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At home

MOTHER FATHER

12. Name Sam Walker

13. Birthplace Not known Not known
(City, town, or county) (State or foreign country)

14. Maiden name Mary Smith

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

16. (a) Informant J.H. Freeman

(b) Address Wyatt, Mo.

17. (a) Burial (b) Date thereof 3/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director John F. Munnell

(b) Address Charleston, Mo.

19. (a) 3-12- (b) J. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th.
year 1940 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Jan 21
1940 to March 1 1940,
that I last saw her alive on March 1 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration 8 mo

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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? _____

(Specify type of place) _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature Paul B. Barr (M. D. or other) med

Address Charleston Mo Date signed 3/11/40

RECEIVED

District Health Officer No. 2,

District File Number 440-848

Date Filed 4/4/40

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.