

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19019

Registrar's No. 67

Registration District No. 67

Primary Registration District No. 5765

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

1. PLACE OF DEATH:

(a) County Mississippi *Ohio Top*

(b) City or town Wyatt *3 miles SOE of town*

(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 8 years

years, months or days

3. (a) PRINT FULL NAME Aubrie English *524*

3. (b) If veteran, name war. No

3. (c) Social Security No. None

4. Sex Male

5. Color or race Col

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

6. (b) Name of husband or wife Palestine English

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased: February 24th 1913

(Month) (Day) (Year)

8. AGE: Years 27 Months 2 Days 13

If less than one day _____ hr. _____ min.

9. Birthplace Lee County Arkansas

(City, town, or county) (State or foreign country)

10. Usual occupation Farm worker

11. Industry or business Farmer

12. Name French English

13. Birthplace Westpoint, Mississippi

(City, town, or county) (State or foreign country)

14. Maiden name Alice Moody

15. Birthplace Monroe County Mississippi

(City, town, or county) (State or foreign country)

16. (a) Informant French English

(b) Address Wyatt, Missouri

17. (a) Burial (b) Date thereof 5/8/1940

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Charleston

18. (a) Signature of funeral director Lair-Nunnelee *Mo*

(b) Address Charleston, Mo

19. (a) 5-8-40 (b) [Signature] *1745*

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

(c) City or town Wyatt, --Rural

(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 April day 6th

year 1940 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb. 7,

1940 to May 5, 19 40

that I last saw him alive on May 5 19 40

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

Immediate cause of death Lobar Pneumonia

Due to Exposure.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: None

Of operations _____

Of autopsy None

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) (a) Means of injury _____

23. Signature [Signature] (M. D. or other) 1

Address 320 - Division St. Cairo, Ill. Date signed 5/7/

Duration 3 MO.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No.

District File Number 640-10

Date Filed 6/5/40

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

John F. Munnick Jr

Licensed Embalmer No. 3851

P. O. Address: Charleston, N.C.

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.