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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29120

Registration District No. 566 | Primary Registration District No. 5764 | Registrar's No. 110

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: Rural-Long Prairie Township (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bertrand, Mo. Route #. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Mississippi
(c) City or town: Rural- Long Prairie Township (If outside city or town limits, write "RURAL")
(d) Street No.: Bertrand, Mo. Rt. #.1. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: James Clarence Tidwell 34
3. (b) If veteran, name war: X X X
3. (c) Social Security No.: X X X
4. Sex: Male
5. Color or race: Col.
6. (a) Single, widowed, married, divorced: single
6. (b) Name of husband or wife: X X X X
6. (c) Age of husband or wife if alive: X X years
7. Birth date of deceased: Nov. (Month) 4 (Day) 1939 (Year)

8. AGE: Years 0 | Months 9 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace: Charleston (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: infant
11. Industry or business: infant

MOTHER FATHER
12. Name: Willie T. Tidwell
13. Birthplace: Holly Springs (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name: Elsie Mae Carter
15. Birthplace: Dumis (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant: Willie T. Tidwell
(b) Address: Rt. 1. Bertrand, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-11-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Charleston, Mo.
18. (a) Signature of funeral director: Lair-Nunnelee Service
(b) Address: Charleston, Mo.
19. (a) 8-12-40 (Date received local registrar) (b) T. A. Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10 year 1940 hour 7 minute 35 A.M.
21. I hereby certify that I attended the deceased from 8-8- 1940 to 8-10 1940; that I last saw him alive on 8-8 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Colitis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

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? 745 (Specify type of place)
While at work? (e) Means of injury

23. Signature: C. C. Presnell (M. D. or other) M. D.
Address: Charleston, Mo. Date signed 8-10-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 940-13
Date Filed 9/3/40

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 the above constitutes grounds for revocation of license.)

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