

Registration District No. **576**

Primary Registration District No. **5762**

Registrar's No. **116**

1. PLACE OF DEATH:
(a) County **Mississippi**
(b) City or town **Charleston R#1**
(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 **2**
In this community **15** years
(Specify whether years, months or days)

3. (a) PRINT FULLNAME **Winnie Snipes 512**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Frank S. Snipes** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **October 1876**
(Month) (Day) (Year)

8. AGE: Years **About 64** Months Days If less than one day
hr. min.

9. Birthplace **Brady County Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At home**

12. Name **Frank Bosely 9**

13. Birthplace **Not known 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Not known 9**

15. Birthplace **Not known 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **F. S. Snipes**

(b) Address **Charleston, Mo R#1**

17. (a) **Burial** (b) Date thereof **8/19/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove-Charleston**

18. (a) Signature of funeral director **Lair-Nunnelee**
(b) Address **Charleston, Mo**

19. (a) **8-17-40** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Mississippi**
(c) City or town **Charleston 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 **August** day **17th**
year **1940** hour **11** minute **a** M.

21. I hereby certify that I attended the deceased from **Aug 9th 1940** to **Aug 17th 1940** that I last saw **alive on Aug 9th 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Dysentery (Flux)**

Due to **Senility**

Due to **[Signature]**

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?

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

23. Signature **Frank S. Snipes** (M. D. or other)
Address **Charleston Mo** Date signed

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 John F. Nummer

Licensed Embalmer No. 3851

P. O. Address Charleston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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

2B
-40
22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29133

Registration District No. 566

Primary Registration District No. 8762

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Tyngsboro
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Winnie Snipes

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

4. Sex 7 5. Color Col 6. (a) Single, widowed, married, divorced m

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

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

8. AGE: all 64 Years Months Days 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) Infant _____

(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) Oct 18 1940 (b) Frank A Vernon (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 aug day 17 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ 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 _____

Duration
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?

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

23. Signature Frank A Vernon (M. D. or other) _____

Address Charleston Mo Date signed _____

SUPPLEMENTAL

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

