

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Mississippi County
 (b) City or town Charleston
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 204 Locust St. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 2 mos. 23 days (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 7
 (c) City or town Charleston 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. 204 Locust St 2
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5- day 26
 year 1941 hour 5:00 minute A.M.

21. I hereby certify that I attended the deceased from 5-21-1941 to 5-25-1941
 that I last saw him alive on 5-21- 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia ✓
 Duration _____

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.

3. (a) PRINT FULL NAME RUFUS C. TARVER

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Baby

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

7. Birth date of deceased March 3 1941
 (Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Charleston, Mo 1
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

MOTHER FATHER { 11. Industry or business _____

12. Name Luther Chas. Jarver

13. Birthplace (Unknown) Arkansas
 (City, town, or county) (State or foreign country)

14. Maiden name Catherine Coleman

15. Birthplace Clarendon, Arkansas
 (City, town, or county) (State or foreign country)

16. (a) Informant Catherine Jarver (mother)

(b) Address 204 Locust St.

17. (a) Burial (b) Date thereof May 26 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director F. D. Sperry

(b) Address Cape Girardeau, Mo.

19. (a) 5-27-41 (b) F. D. Sperry
 (Date received local registrar) (Registrar's signature)

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

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

23. Signature W. A. Lingel (M. D. or other) _____

Address 204 S. Locust St. Charleston Date signed 5-27-41

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

107

RECEIVED

District Health Officer No. 2

District File Number 41-69

Date Filed 6/2/41

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.....

Body was not embalmed Registered Apprentice No.
working under my personal supervision.

Signed Frank Sparks

Licensed Embalmer No.

P. O. Address Cape Girardeau Mo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18439

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Miss
(b) City or town Charleston
(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)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rufus C. Turner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
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: Years Months Days If less than one day
2 23 _____ 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 _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 26
year _____ 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: Broncho Pneumonia
Due to: Pertussis

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 M. A. Singal (M. D. or other)
Address 204 S. Locust St Charleston, Mo

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

SUPPLEMENTARY

7-24
41

S-18439 1941