

FILED JUN 19 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18512

Registration District No. 604605 Primary Registration District No. 5802 431 Registrar's No.

1. PLACE OF DEATH:

(a) County NEW MADRID
 (b) City or town CATRON
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: NO
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution NO
 In this community 4 YEARS
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME

NED WYNE
 3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex M 2 5. Color or race COLORED 6. (a) Single, (widowed) married, divorced WIDOWED
 6. (b) Name of husband or wife MARY WYNE 6. (c) Age of husband or wife if alive 55 years
 7. Birth date of deceased JUN 20 1904
 (Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 25 If less than one day hr. min.

9. Birthplace UNK. 1 MISS
 (City, town, or county) (State or foreign country)

10. Usual occupation FARM WORK

11. Industry or business NO

12. Name JIM WYNE

13. Birthplace PUSHMATAHA 1 MISS
 (City, town, or county) (State or foreign country)

14. Maiden name ROKIE BENNETT

15. Birthplace UNK. 1 MISS
 (City, town, or county) (State or foreign country)

16. (a) Informant ALBERT WYNE

(b) Address CATRON, MO

17. (a) BURIAL (b) Date thereof JUNE 11-1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CATRON

18. (a) Signature of funeral director COUNTY CASE

(b) Address NEW MADRID COUNTY

19. (a) 6-16-41 (b) W. W. [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEW MADRID
 (c) City or town CATRON
 (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 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 15
 year 1941 hour 4:00 minute A.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 By RECORD WAS PULMONARY TUBERCULOSIS
 Due to _____

Due to _____
 Other conditions (Include pregnancy within 3 months of death) 17/12

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? _____

(Specify type of place)
 (e) While at work? _____ (e) Means of injury _____
 23. Signature [Signature] County Catron
 Address New Madrid Date signed June 15-1941

(Licensed Embalmer's Statement on Reverse Side)

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

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..... *No*

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.

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Cairo, TI
(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)

3. (a) PRINT FULL NAME Ned Wayne

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased June 20 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 0 25 hr min.

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

10. Usual occupation Farm work

11. Industry or business _____

12. Name Jim Wayne

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

14. Maiden name Bennett (City, town, or county) (State or foreign country)

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

16. (a) Informant Albert Wayne

(b) Address Cairo Mo

17. (a) B (b) Date thereof 6-16-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cairo

18. (a) Signature of funeral director County Case

(b) Address New Madrid

19. (a) 8-27-41 (b) [Signature]
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month June day 18
year 1941 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 _____
By Record of Pulmonary -
ary Tuberculosis

Due to _____

Due to _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Leo Hedgereth (M.D. or other) _____
Address New Madrid Date signed 1941

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

MOTHER FATHER

STIPPLED

MEDICAL CERTIFICATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-18572 1941