

Anderson

STANDARD CERTIFICATE OF DEATH

State File No.

32757

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard  
 (b) City or town Charter Oak  
 (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 Jimmie Carrol Greer

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 U

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

7. Birth date of deceased 6 20 1940  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 2 22 hr. min.

9. Birthplace Charter Oak 0 Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER  
 { 12. Name Everett Greer  
 { 13. Birthplace Canalou Mo.  
 { 14. Maiden name Cledis Simpson  
 { 15. Birthplace Canalou U Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Clarence Simpson  
 (b) Address Canalou Mo.

17. (a) Burial (b) Date thereof 9/13/41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Essex Mo.

18. (a) Signature of funeral director Hunter Albrecht  
 (b) Address Sikeston Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard / 03  
 (c) City or town Charter Oak  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.  
 (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 12  
 year 1941 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from 9-9-41 to 9-12-41  
 that I last saw him alive on 9-12-41  
 and that death occurred on the date and hour stated above.

Immediate cause of death: acute heart failure due to toxemia  
 Due to: acute bacillary dysentery  
 Due to: September 4 day

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) END  
 (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 [Signature] (M. D. or 0)  
 Address Sikeston Date signed 9/16/41

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

105  
000

X26330

RECEIVED

District Health Office No. 2,

District File Number 1041-1371

Date Filed 10/6/46

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH

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.....

Not Embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed Hunter Albritton.....

Licensed Embalmer No. 4210.....

P. O. Address Sikeston.....

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

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Charter Oak  
(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 years, months or days)

In this community \_\_\_\_\_

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 Jimmie C. Greer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 Day 12  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him/her die on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased 6-20-1940  
(Month) (Day) (Year)

8. AGE: Years 1 Months 2 Days 3 If less than one day Hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Nov. 20, 41 (b) J.P. Brandon  
(Date received local registrar) (Registrar's signature)

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—RECORD

SUPPLEMENTARY

