

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

DEC 22 1941 1051  
Registration District No. \_\_\_\_\_

Primary Registration District No. **5768**

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

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Rural Dorena, Dorena, Mo.  
(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 2 mo. 14 Day (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 15 miles Southeast of E. Prairie,  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOE ANN DAVIS  
3. (b) If veteran, name war ✓  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 25  
year 1941 hour 11.15 minute P.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw her alive on Oct 25 / 1941 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: August 11th 1941  
(Month) (Day) (Year)

Immediate cause of death: Enteritis & Colitis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
2 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Dorena, Missouri  
(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.

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Arthur Edgar Davis  
13. Birthplace 1 Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Elizabeth Ferguson  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
16. (a) Informant Arthur Edgar Davis  
(b) Address Dorena, Missouri  
17. (a) Burial (b) Date thereof Oct. 26, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation W. J. W. East Prairie  
18. (a) Signature of funeral director Chavis Shelly  
(b) Address East Prairie, Mo.  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature A. J. Martine (M. D. or other) \_\_\_\_\_  
Address East Prairie Date signed \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

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STATEMENT BY LICENSED EMBALMER

*not embalmed*

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 *Travis Shelby*

Licensed Embalmer No. *2726*

P. O. Address *East Prairie, La.*

**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.**

STANDARD CERTIFICATE OF DEATH

State File No. 38862

Registration District No. 1051

Primary Registration District No. 576P

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

1. PLACE OF DEATH

(a) County Mississippi

(b) City or town Bara  
(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 Opel Ann Harris

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 Aug. 11, 1944  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>2</u>		_____ min.

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

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

11. Industry or 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)

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

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

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

(c) Place: burial or cremation W. O. W. East Prairie Mo

18. (a) Signature of funeral director Provis W. Sheet

(b) Address East Prairie Mo

19. Ann M. St. (b) Fannie Hodges  
(Date received local registration) (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 5  
year 1991 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21: I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

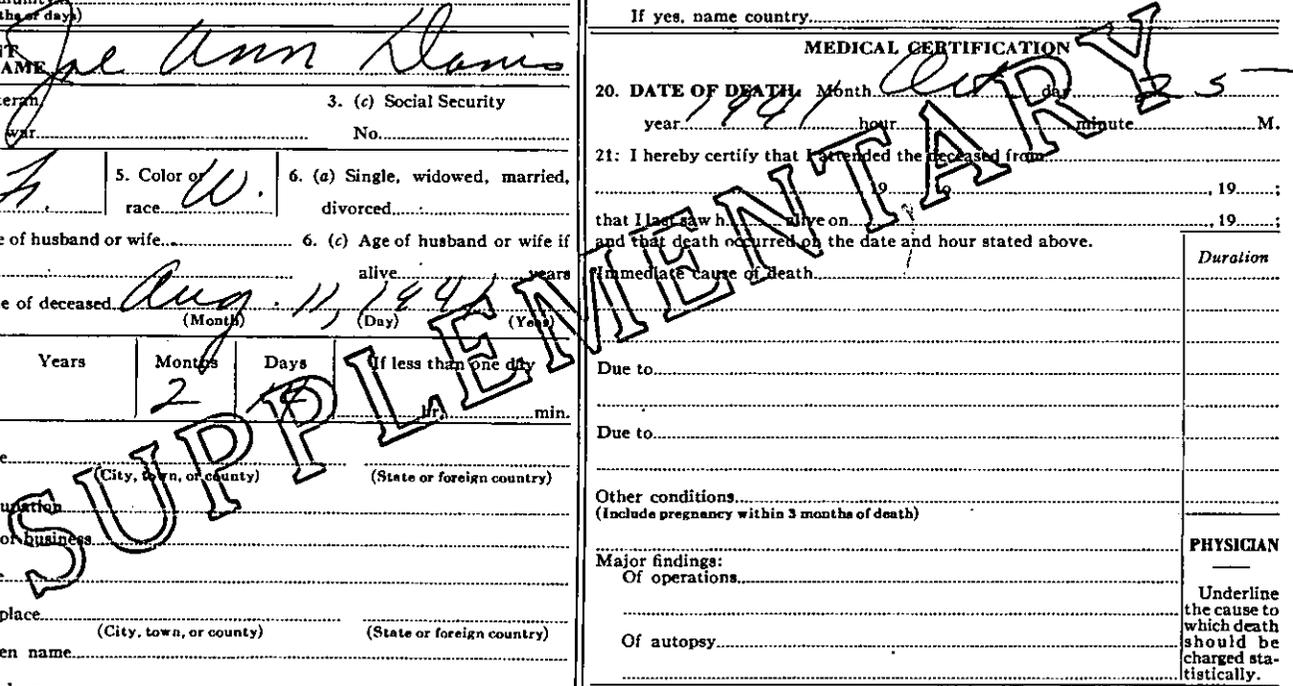
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(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. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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