

Registration District No. **566**

Primary Registration District No. **3030**

1. PLACE OF DEATH:

(a) County **MISSISSIPPI**
(b) City or town **CHARLESTON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
315 So Elm - County Ward 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
3 (Specify whether years, months or days)
In this community **3**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **MISSISSIPPI**
(c) City or town **CHARLESTON**
(If outside city or town limits, write "RURAL")
(d) Street No. **5-15 ELM STREET**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **No**

3. (a) PRINT FULL NAME **TOM GERRING**

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

4. Sex **MALE** 5. Color or race **COLOR** 6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive **NONE** years
7. Birth date of deceased **JAN 1, 1865**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	2	8	hr. min.

9. Birthplace **STATE OF MISSISSIPPI**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARM LABORER**

11. Industry or business **FARMING**

MOTHER FATHER
12. Name **NOT KNOWN**
13. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name **NOT KNOWN**
15. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS MAUDE FINLEY**

(b) Address **CHARLESTON, Mo**

17. (a) **BURIAL** (b) Date thereof **3-10-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAK GROVE CHARLESTON, Mo**

18. (a) Signature of funeral director **John F. Hummel**

(b) Address **CHARLESTON, Mo**

19. (a) **3-11-42** (b) **J. A. Vernon**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **9TH**
year **1942** hour **5** minute **P** M.

21. I hereby certify that I attended the deceased from **July 3-42**
19... to **Mar 9-42** 19...
that I last saw him alive on **Mar 5-42** 19...
and that death occurred on the date and hour stated above.

Immediate cause of death **Mitral Insufficiency**
Due to **Hypertension**

Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **926**
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 J. Vernon** (M. D. or other)
Address **Charleston Mo** Date signed

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

RECEIVED

District Health Office No. 2,

District File Number 442-497

Date Filed 4-13-42

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.