

Registration District No. 217

Primary Registration District No. 3045

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:  
319 W. CYPRESS /  
(If not in hospital or institution, write street number or location)

(d) -Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 YEARS (Specify whether  
years, months or days)

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. 319 W. CYPRESS ST  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country. NONE

3. (a) PRINT FULL NAME LEONA WHITMORE

3. (b) If veteran, name war. NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race. COLOR

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

6. (b) Name of husband or wife. WALTER WHITMORE

6. (c) Age of husband or wife if alive. 79 years

7. Birth date of deceased. APRIL 9, 1869  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
73	7	12	hr. _____ min. _____

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

10. Usual occupation. AT HOME

11. Industry or business. HOUSEWIFE

12. Name. THOMAS KOLHEIN

13. Birthplace. STATE OF VIRGINIA  
(City, town, or county) (State or foreign country)

14. Maiden name. NO RECORD

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

16. (a) Informant. W.L. BRANION

(b) Address. 319 W. CYPRESS - CHARLESTON, MO

17. (a) BURIAL (b) Date thereof. 11-25-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. OAK GROVE - CHARLESTON MO

18. (a) Signature of funeral director. [Signature]  
(b) Address. CHARLESTON, MO

19. (a) 1-1-42 (b) D.G. Moore  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 21ST  
year 1942 hour 12 NOON

21. I hereby certify that I attended the deceased from June 1, 1942 to Nov 21, 1942  
that I last saw her alive on Nov 20, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death. Carcinoma of Cervix  
metastatic.

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

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

Other conditions. (Include pregnancy within 3 months of death) HSA

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. [Signature] (M. D. or other) \_\_\_\_\_

Address. CHARLESTON MO Date signed. 11/21/42

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

67  
1  
2

RECEIVED  
District Health Office No. 2,  
District File Number 143-56  
Date Filed 7-6-43

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**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 John F. Kinnel Jr  
Licensed Embalmer No. 3851  
P.O. Address Charleston 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.**