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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **18437**  
Registrar's No. **24**

FILED JUN 14 1943  
Registration District No. **217**

Primary Registration District No. **3044**

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:  
**Six CLEVELAND**  
(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 **LILLIAN RUSSELL SIMMERMAN**

3. (b) If veteran, name war **INFANT**

3. (c) Social Security No. **INFANT**

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **INFANT**

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased **MAY 1 1943**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	9 hr. 15 min.

9. Birthplace **CHARLESTON Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **INFANT**

11. Industry or business \_\_\_\_\_

12. Name **RUSSELL SIMMERMAN**

13. Birthplace **ELKVILLE ILLINOIS**  
(City, town, or county) (State or foreign country)

14. Maiden name **LOUISE MANNON**

15. Birthplace **LOUEVILLE TENNESSEE**  
(City, town, or county) (State or foreign country)

16. (a) Informant **RUSSELL SIMMERMAN**

(b) Address **Six Cleveland - Charleston, Mo**

17. (a) **BURIAL** (b) Date thereof **5-1-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAK Grove - Charleston Mo**

18. (a) Signature of funeral director **Paul F. Munnell**

(b) Address **Charleston, Mo**

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **MISSISSIPPI**

(c) City or town **CHARLESTON**  
(If outside city or town limits, write "RURAL")

(d) Street No. **512 CLEVELAND ST**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **15**  
year **1943** hour **10** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **May 7 April 30** 1943 to **May 1** 1943  
that I last saw him alive on **May 1** 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death **Aspiration 7 mo.**

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 **Paul F. Munnell** (or other) \_\_\_\_\_

Address **Charleston Mo** Date signed **5/14/43**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2

District File Number 643-797

Date Filed 6-8-43

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.

FILE

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 217

Primary Registration District No. 3043

Registrar's No. 34

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:

(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 Lillian R. Sumner

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 S

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

7. Birth date of deceased: May 1 (Month) (Day) (Year)

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

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

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

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

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

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

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

19. (a) June 1 - 43 (b) Mrs Lou Moore (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her 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 \_\_\_\_\_

WRITE IN ONLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-18437