

No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11526

FILED APR 7 1944

Registration District No. 2047

Primary Registration District No. 304V

State File No. _____

Registrar's No. 28

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:
Vine St. /
(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 20 yrs.

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. Vine St.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Robert Ford

3. (b) If veteran _____ name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1944 hour 6 minute 0 P.M.

4. Sex M 5. Color or race Colored

6. (a) Single, widowed, married, 9 divorced

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 14th 1944 to March 21st 1944
that I last saw him alive on Aug 16th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Infarction

Duration _____

8. AGE: Years 78 Months _____ Days _____ If less than one day
hr. _____ min. _____

Due to _____

Due to _____

9. Birthplace N.K. Georgia /
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings:
Of operations _____

11. Industry or business _____

Of autopsy _____

MOTHER FATHER { 12. Name NOT KNOWN

13. Birthplace Not Known 9
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Know 9
(City, town, or county) (State or foreign country)

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

16. (a) Informant Alva Renfro

(b) Address Charleston, Mo.

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

17. (a) Burial (b) Date thereof 3-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) _____

(c) Place: burial or cremation Oak Grove Charleston, Mo.

(b) Date of occurrence _____

18. (a) Signature of funeral director Lair-Nunneled

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

(b) Address Charleston, Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

19. (a) Apr 1 - 44 (b) Mrs. Lon Moore
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

20. 1251

(c) Means of injury _____

23. Signature Frank J. Vernon (M. D. or other) _____

Address Charleston Mo Date signed 3-27-44

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

RECEIVED

District Health Office No. 2,

District File Number 44-469

Date Filed 4-4-44

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 Not Embalmed
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

april

Registration District No.

217

Primary Registration District No.

3045

Registrar's No.

28

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 NAMERobert Ford

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex
- m
5. Color or race
- c
6. (a) Single, widowed, married,
-
- divorced
- single

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

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

8. AGE: Years Months Days Unless than one day
-
- 78
- min.

9. Birthplace.....
-
- (City, town, or county) (State or foreign country)
- Georgia

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.....

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

- (b) Address.....

- 19.
- April 20/44
- (b)
- Mrs. Lou Marie
-
- (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
- March
-
- year
- 1944
- 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 sta-
tistically.

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 PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

11526