

FILED NOV 20 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3045

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

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:  
209 Vine St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 months  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ida Braboy  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Geo. Braboy  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 6, 1873  
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 24  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Aikens, S. Carolina  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Jim Callahan  
13. Birthplace Aikens, S. Carolina  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Ann Johnson  
15. Birthplace Aikens, S. Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Melrose May  
(b) Address 209 Vine St., Charleston, Mo.  
17. (a) Removal (b) Date thereof Nov. 3, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Holly Grove, Arkansas

18. (a) Signature of funeral director F. J. Sparks  
(b) Address Cape Girardeau, Missouri  
19. (a) W. L. L. L. (b) Mrs. Lon M...  
(Date received local registrar) (Registrar's signature)

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. 209 Vine St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30  
year 1944 hour 11 minute 15 A.M.  
21. I hereby certify that I attended the deceased from 10-30-44 to 10-30-44  
that I last saw her alive on 10-30-44  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Lobar Pneumonia  
Due to \_\_\_\_\_  
Influenza  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
33b  
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) Means of injury 0  
23. Signature W. A. Fungal (M. D. or other)  
Address 204 S. Locust, Charleston Date signed 10/31/44

Duration  
8 days  
2 wks  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 114-1547

Date Filed 11-15-44

**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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau, 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.**