No. 2
—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 6 1945

Registration District No. 56

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4086

State File No. 40839

Registrar's No. 33

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town TINA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Home in Tina Missouri
(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 Since March 1st 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Livingston
(c) City or town Bedford Missouri Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mac. D. Singleton
3. (b) If veteran, name war X
3. (c) Social Security No. X

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sally Kathrine Singleton
6. (c) Age of husband or wife if alive P years
7. Birth date of deceased Feb (Month) 1st (Day) 1879 (Year)

8. AGE: Years 65 Months 10 Days 10 If less than one day hr. min.

9. Birthplace Bedford (City, town, or county) Livingston Co (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name John J Singleton
13. Birthplace Bedford (City, town, or county) Missouri (State or foreign country)
14. Maiden name Sadie Mc Irwin
15. Birthplace Chillicothe (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs Sally Kathrine Singleton
(b) Address Tina Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Arkadelphia
18. (a) Signature of funeral director Clifford W Huston
(b) Address Tina Missouri
19. (a) 12-12-44 (Date received local registrar) (b) Mrs Edgar Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11 year 1944 hour 10 minute A M.
21. I hereby certify that I attended the deceased from August 1, 1944, to December 11, 1944; that I last saw him alive on December 10, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: CARDIAC FAILURE & PASSIVE Congestion of LIVER	6 months
Due to: Generalized Edema	2 wks.
Due to: Uremia	6 days
Due to: No	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. R. W. Mattany (M. D. or other) D.O.
Address Tina Missouri Date signed 12-11-44

(Licensed Embalmer's Statement on Reverse Side)

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 Clifford W. Austin

Licensed Embalmer No. 3233

P. O. Address Tina Missouri

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 56 Primary Registration District No. 4086 Registrar's No. 33

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Tina
(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)

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

3. (a) PRINT FULL NAME Mae D. Singleton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. 1 1879
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to Uremia from failing heart & kidneys and

Other conditions follow up of Nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION
Of autopsy REQUESTED

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Dr R W Matheus (M. D. or other) DO

Address Tina Mo Date signed 1-7-45

SUPPLEMENTARY

40839