

No. 2
-2-43
5-17-39
X35897

FILED MAR 12 1945
Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 11

1. PLACE OF DEATH

(a) County Pemiscot
 (b) City or town Cassidyville, Mo
 (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 _____
 In this community 8 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot
 (c) City or town Cassidyville 19
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 2
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Sam White
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
 year 1945 hour 10 minute 30 P.M.

4. Sex Male 5. Color Colored (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 24 1926
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years 18 Months 7 Days 12 If less than one day _____ hr. _____ min.
 9. Birthplace Greenwood Mississippi
 (City, town, or county) (State or foreign country)
 10. Usual occupation Labour

Immediate cause of death gun shot in Right Shoulder and chest.
 Duration _____

11. Industry or business
 12. Name Ed White
 13. Birthplace Columbus Miss
 (City, town, or county) (State or foreign country)
 14. Maiden name James Sharp
 15. Birthplace Columbus Miss
 (City, town, or county) (State or foreign country)

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy none

MOTHER FATHER
 16. (a) Informant Rose W. White
 (b) Address Box 77, Cassidyville, Mo
 17. (a) Removal (b) Date thereof 1-12-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Jackson Avenue
 18. (a) Signature of funeral director Reman Furthem
 (b) Address St. Louis, Mo. Box 121
 19. (a) 3-3-1945 (b) Jessie N. Markey
 (Date received local registrar) (Registrar's signature)

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) Justifiable homicide
 (b) Date of occurrence 1/6-45
 (c) Where did injury occur? Cassidyville Pemiscot Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Buffet
 While at work? _____ (Specify type of place)
 (e) Means of injury gun shot
 23. Signature Jessie N. Markey Coroner (M.D. or other)
 Address St. Louis, Mo 3 Date signed 1-7-45

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

1206

2-45-49

MAR 27 1945

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.....

E. E. White

Licensed Embalmer No.....

4168

P. O. Address.....

Southsville, S.C.

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.

Registration District No. 270 Primary Registration District No. 3050

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Caruthersville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: (None)
(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 Sam White

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased May 24 (Month) (Day) (Year)

8. AGE: Years 18 Months 7 Days _____ If less than one day _____ min.

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

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-3-1945 (b) Jessie T. Markey (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 Jan year 1945 day _____ 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 _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

6830