

FILED MAR 16 1945

Registration District No. 1245

Primary Registration District No. 4330

Registrar's No. 7

1. PLACE OF DEATH: *Mississippi*

(a) County *East Prairie, Mo.*

(b) City or town *East Prairie, Mo.*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
*Residence!*  
(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 *Missouri* (b) County *Mississippi*

(c) City or town *East Prairie, Mo.*  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) *2*

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *SHELIA GAILEE BRITT.*

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* day *1th* year *1945* hour *4* minute *9* M.

4. Sex *Female* 5. Color or race *White*

6. (a) Single, widowed, married, divorced. *0*

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

21. I hereby certify that I attended the deceased from *Attended* to *Coroner* that *last saw* *alive* on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

7. Birth date of deceased: *Sept 25, 1944*  
(Month) (Day) (Year)

Immediate cause of death: *Mitral Insufficiency*

8. AGE:	Years	Months	Days	If less than one day
	<i>0</i>	<i>4</i>	<i>6</i>	hr. min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace: *Flint, Michigan*  
(City, town, or county) (State or foreign country)

Other conditions: *Malnutrition*  
(Includes pregnancy within 3 months of death)

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy *none*

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

12. Name *Wayne Edward Britt*

13. Birthplace *Prosser, Mo.*  
(City, town, or county) (State or foreign country)

14. Maiden name *Martha Rebecca Hill*

15. Birthplace *Lepp, Tenn.*  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant *Wayne Edward Britt*

(b) Address *East Prairie, Mo.*

17. (a) *Burial* (b) Date thereof: *2-2-45*  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence *2-1-1945*

(c) Where did injury occur? *2816 W. Home*  
(City or town) (County) (State)

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

(c) Place: burial or cremation *Dogwood*

18. (a) Signature of funeral director *Thomas Shelby*

(b) Address *East Prairie, Mo.*

19. (a) *3-10-1945* (b) *James E. Byrnes*  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury *3*

23. Signature *John F. Minnie Jr.* (Dr. D. of \_\_\_\_\_)  
*Charleston, Mo.* Date signed *2/3/45*

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

7  
2  
0

1271

RECEIVED

District Health Office No.

District File Number 345-44

Date Filed 3/14/44

**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 Travis Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie, 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.**