

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 15 1945
Registration District No. 278

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14001

State File No.
Registrar's No. 17

Primary Registration District No. 5789

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

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: Osborn
(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: 30 days
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME: RAYLEE FAVES
(b) If veteran, name war: ✓
(c) Social Security No.: ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 3
year 1945 hour 9 minute P M.
21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death:

4. Sex: Male
5. Color or race: white
6. (a) Single, widowed, married, divorced: 0
6. (b) Name of husband or wife:

Duration
Due to: (Unknown)
Other conditions: 200c
Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy: N.I.O.
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.....

7. Birth date of deceased: Dec 3 1944
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day

9. Birthplace: Lake Co. Tenn
(City, town, or county) (State or foreign country)
10. Usual occupation:

MOTHER FATHER
11. Industry or business:

12. Name: Thomas William Lee Faves
13. Birthplace: Middle Tenn
(City, town, or county) (State or foreign country)
14. Maiden name: Mary Francis Owens
15. Birthplace: Yorktown Tenn
(City, town, or county) (State or foreign country)
16. (a) Informant: Thomas William Lee Faves
(b) Address: East Prairie, Mo. Rt. 2
17. (a) Burial (b) Date thereof: 3-
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation:

18. (a) Signature of funeral director: Thomas Shelby
(b) Address: East Prairie Mo
19. (a) 4-8-1945 (b) A. Bigman
(Date received local registrar) (Registrar's signature)

Physician
Underline the cause to which death should be charged statistically.
23. Signature: (M. D. or other)
Address: Date signed:

1271

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No

District File Number 445-3

Date Filed 4/14/42

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.....

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.

2nd Query
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14081

Registration District No. 218

Primary Registration District No. 5789

Registrar's No. 17

1. PLACE OF DEATH:

- (a) County Mississippi
(b) City or town Dorena
(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 30 da
years, months or days)3. (a) PRINT FULL NAME Raylee Eaves

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
- s

6. (b) Name of husband or wife _____

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

7. Birth date of deceased
- Dec 3 1944
-
- (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
-
- (City, town, or county) (State or foreign country)

14. Maiden name _____
-
- (City, town, or county) (State or foreign country)

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

2. USUAL RESIDENCE OF DECEASED:

- (a) State
- Tenn
- (b) County
- Lake

- (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
- 11
- day _____
-
- year
- 1945
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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

