

No. 2
15-43
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X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10146

Registration District No. 217 Primary Registration District No. 3045 State File No. _____ Registrar's No. 21

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All of life years, months or days

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. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charley Montjoy
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 2 race negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased July 18 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 7 5 hr. _____ min.

9. Birthplace Wolf Island Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business
12. Name Louis Montjoy 9
13. Birthplace Not Known 9
(City, town, or county) (State or foreign country)
14. Maiden name Martha Whipple
15. Birthplace Not Known 9
(City, town, or county) (State or foreign country)

16. (a) Informant Charley Montjoy, Jr.
(b) Address Charleston, Missouri
17. (a) Burial (b) Date thereof 2-28-'46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director John F. Hunsicker
(b) Address Charleston, Mo
19. (a) 3-6-46 (b) Mrs. John Bondurant
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 23
year 1946 hour 7 minute 30 p. M.

21. I hereby certify that I attended the deceased from Attended as Doctor 19 46
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death Crushed skull, Crushed chest, Broken neck and back
Due to Unavoidable accident auto pedestrian collision Hwy 60 in City Charleston at 2nd St.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy no autopsy
1700-8
21

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 107
(b) Date of occurrence 2-23-1946
(c) Where did injury occur? Charleston Miss Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place - Hwy 60
While at work? no (Specify type of place) (e) Means of injury Auto accident
23. Signature John F. Hunsicker (M. D. or D. O.)
Address Charleston, Mo Date signed 2-22-46

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. _____

District File Number 446-446

Date Filed 4-4-46

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 Edward E. Nunnelle
Licensed Embalmer No. 4164
P. O. Address Charleston, 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.

Registration District No. 217

Primary Registration District No. 3045

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

4. Sex m 5. Color or race negro 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 July 18 1888 (Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days _____ (Unless than one day) hr. _____ min.

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

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) _____ (b) Mrs. J. Lee Bondurant (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 7 year 1946 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 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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

10140