

S. No. 2  
 FORM-2-43  
 Rev. 5-17-39  
 I. X35597

28545

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
 Registrar's No. 52

FILED AUG 20 1947

Registration District No. 270

Primary Registration District No. 30505967

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

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: Rural Route 1  
(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 8 Days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Pemiscot  
 (c) City or town Caruthersville Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Rural Route 1  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joe Presberry  
 3. (b) If veteran, name war X  
 3. (c) Social Security No. X

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 3rd,  
 year 1947 hour 9 minute 45 A. M.

4. Sex Male 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced X  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive X years  
 7. Birth date of deceased July 27, 1947  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 2, 1947, to Aug 3, 1947;  
 that I last saw him alive on Aug 2, 1947;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death: Telomer Neurotoxin  
 Due to defection of antibodies  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) none

9. Birthplace Caruthersville, Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation X

Major findings: none  
 Of operations \_\_\_\_\_  
 Of autopsy none  
 PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business X  
 12. Name Hayes Presberry  
 13. Birthplace Brisco, Ark.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Emma Lee Allen  
 15. Birthplace Mississippi, Co., Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Hayes Presberry  
 (b) Address Caruthersville, Mo. R.1

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 \_\_\_\_\_

17. (a) Burial (b) Date thereof 8/4/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Morgan Ridge Cem.  
 18. (a) Signature of funeral director J. Smith Funeral Home  
 (b) Address Caruthersville, Mo.  
 19. (a) 8-15-47 (b) Jessie B. Wilks  
(Date received local registrar) (Registrar's signature)

23. Signature: [Signature] (M. D. or other)  
 Address Caruthersville Date signed 8/19/47

8-47-243

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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.....

Body was not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*James A. Osburn*

Licensed Embalmer No. *4485*

P. O. Address *Lawrenceville, Ga.*

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.