

FILED NOV 13 1947

State File No. \_\_\_\_\_

Registration District No. 217

Primary Registration District No. 5786

Registrar's No. 103

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Wyatt Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
(c) City or town Wyatt (rural)  
(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 ALBERT PRESSON

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced div  
6. (b) Name of husband or wife Allie Presson dec. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased august 29 1874  
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Mississippi Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation retired Farmer

11. Industry or business

MOTHER FATHER { 12. Name unknown  
13. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Presson  
(b) Address Deventer, Mo.

17. (a) Burial (b) Date thereof Oct. 15, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dogwood Cemetery Dogwood

18. (a) Signature of funeral director Edw. J. ...

(b) Address East Main St. ...

19. (a) 11-6-47 (b) Mrs. John ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month oct day 13  
year 1947 hour 11 minute 4 A. M.

21. I hereby certify that I attended the deceased from June 1947 to Oct 13 1947  
that I last saw him alive on Oct 12 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy, cerebral  
arterio-sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy 87A

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 \_\_\_\_\_

23. Signature Edw. J. ... (M. D. or other) \_\_\_\_\_  
Address Deventer Mo. Date signed 10/15/47

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

RECEIVED

District Health Office No. 2,

District File Number 1147-1454

Date Filed 11-11-47

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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.....

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

working under my personal supervision.

Signed Frank Shelby

Licensed Embalmer No. 2526

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.**