

No. 2
-12-45
-5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5532
Registrar's No. 9

FILED MAR 1 1948
Registration District No. 2488

Primary Registration District No. 5790

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 1, Box 689 - Pinhook
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Leroy Gary

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

4. Sex Male 2 5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lydie Bell Gary 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased July 16, 1907
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

40	6	2	hr. min.
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9. Birthplace Washington County, Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John Gary 9

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Theresa Johnson

15. Birthplace Louisiana 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lydie Bell Gary

(b) Address R. 1, Box 689, Charleston, Mo.

17. (a) Burial (b) Date thereof Jan 25 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director F. D. Sparks

(b) Address Cane Girardeau, Mo.

19. (a) 2-6-48 (b) Gertrude G. Harper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi 7

(c) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. Route 1, Box 689
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18
year 1948 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from 11-21-1947 to 1-17-1948
that I last saw him alive on 1-17-1948
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus Meningitis 2 wks.
Chronic Otitis Media Suppurativa
3 mos. (Hist.)

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)
Means of injury _____

23. Signature W. A. Lingaly (D. No.)
Address 2045 Locust St. Charleston, Mo. 6-20-48

RECEIVED

District Health Office No. 2

District File Number 248-291

Date Filed 2-25-48

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 Sparks*

Licensed Embalmer No. *3455*

P. O. Address *Cape Girardeau 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.