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MISSISSIPPI STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Lincoln State Miss Registration District No. 496 File No. 21

Village Caseyville or Primary Registration Dist. No. 9962 Reg. No. 21

(If death occurred in a hospital or institution, give its NAME instead of street and number)

City No. St., Ward

2 FULL NAME Sidney Ferdnand

(a) Residence. No. 13 mi Caseyville Road Beat #5 Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: M.

4 COLOR OR RACE: B.

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year)

7 AGE: 36 YEARS; Months —; DAYS —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Hand
(b) General nature of Industry, business, or establishment in which emlyoyed (or employer): Mound Dun
(c) Name of employer

9 BIRTHPLACE (city or town) (State or Country): Miss

10 NAME OF FATHER: Willern Ferdnand

11 BIRTHPLACE OF FATH'R (city or town) (State or Country): Miss

12 MAIDEN NAME OF MOTHER: Lessie Hatter

13 BIRTHPLACE OF MOTHER (city or town) (State or Country): Miss

14 Informant: James Ferdnand
(Address): Brookhaven Rt 6

15 Filed 8/4 1921 Dr. D. W. Magee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) 8/3 1921

17. I HEREBY CERTIFY, That I attended the deceased from ...., 19...., to ...., 19....,

that I last saw h.... alive on ...., 19....,

and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Brights disease

(duration) yrs mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed D. W. Magee M. D.

8/4/ 1921 (Address) Wesson M. S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 Place of Burial, Cremation or Removal: Mt Zion — Date of Burial: 8/4 1921

20 UNDERTAKER: C H Hartman — ADDRESS: B Haven

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every Item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 4