

MISSISSIPPI STATE DEPARTMENT OF HEALTH  
VITAL RECORDS  
CERTIFICATE OF DEATH  
STATE OF MISSISSIPPISTATE  
FILE NO.

8044

REGISTRAR'S NO. 33

BIRTH NO.		1. PLACE OF DEATH a. COUNTY <u>Itawamba County</u>		2. USUAL RESIDENCE (When deceased lived. If institution, residence before admission.) a. STATE <u>Miss.</u> b. COUNTY <u>Itawamba</u>	
b. CITY (If outside corporate limits, write RURAL) OR TOWN <u>Rural</u>		c. LENGTH OF STAY (in this place) <u>49 yrs</u>		c. CITY (If outside corporate limits, write RURAL) OR TOWN <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>		d. IF RURAL GIVE LOCATION <u>Fulton, Miss. Rt. 2</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 15, 1951</u>	
3. NAME OF DECEASED a. (First) <u>Martha Melvina Owens</u> b. (Middle) <u>S-20</u> c. (Last)		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	
8. DATE OF BIRTH <u>Sept. 18, 1866</u>		9. AGE (In years) (Months) (Days) <u>84 7 27</u>		10. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Thomas Houston Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Fielder</u>		17. INFORMANT <u>George Owens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none none</u>		16. SOCIAL SECURITY NO. <u>none</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Chronic Myocarditis</u>		II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		4222	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>W.L. Cobb, M.D.</u>		23b. ADDRESS <u>Fulton Miss</u>		23c. DATE SIGNED <u>5-22-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 17, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>	
24d. LOCATION (City, town, or county) (State) <u>Itawamba County Miss.</u>		24e. REGISTRAR'S SIGNATURE <u>Max Myrtle Dillentine</u>		24f. ADDRESS <u>Fulton, Miss.</u>	
DATE REC'D BY LOCAL <u>5-22-51</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE.

Alton B. Cobb, M.D.  
Alton B. Cobb, M.D.  
STATE HEALTH OFFICER

April 7, 1986

David Lohrich  
David Lohrich  
STATE REGISTRAR

WARNING: It is illegal to alter or counterfeit this copy.

