

N. E.—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.

REC'D FEB 27 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3661  
Do not use this space.

1. PLACE OF DEATH

(a) County Ripley Registration District No. 750  
 (b) Township Harris Primary Registration District No. 5991 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

616 Alpha Belle Locher  
 (a) Residence, No. Douglas Mo. Rt. 1 St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adolph  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 1, 1881  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
57 57 11 23

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN. 23 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 1-23-39, 1939, to 1-23-39, 1939.  
 I last saw her alive on 1-21-39, 1939. Death is said to have occurred on the date stated above, at 4:15 P.M.  
 The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset 1-22-39  
Cerebral Hemorrhage  
 Other contributory causes of importance: HTA

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ashley, Ill.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? no.

FATHER 13. NAME James Houser  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Geniv.

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

MOTHER 15. MAIDEN NAME Stephens  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ashley, Ill.

17. INFORMANT (ADDRESS) Adolph Locher

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL at home Cem.  
 PLACE Douglas DATE 1-25-39

24. Was disease or injury in any way related to occupation of deceased? NO.  
 If so, specify \_\_\_\_\_  
 (Signed) C. G. Jordan, M. D.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. E. Jordan  
Douglas

20. FILED Jan. 25, 1939 C. B. Johnston  
 Local Registrar.

(Address) Douglas Mo.

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

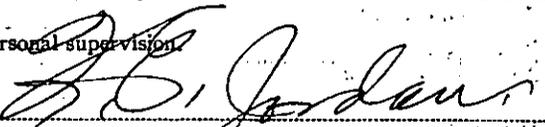
**STATEMENT BY LICENSED EMBALMER**

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



Licensed Embalmer No. 3200

P. O. Address Dorchester

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, above space should be left blank.