

N. B.—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.

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. 115

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Brookfield Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
(Specify whether
In this community 50 years
years, months or days)

3. (a) PRINT FULL NAME SALLIE LACY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife James W. Lacy 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 15, 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 2 If less than one day hr. _____ min. _____

9. Birthplace Nashville Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
MOTHER FATHER { 12. Name Not Known
13. Birthplace Not Known
(City, town, or county) (State or foreign country)
14. Maiden name Not Known
15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature N. Wright
(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof 12-19-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Michael Cemetery

18. (a) Signature of funeral director Rusk Funeral Home
(b) Address Brookfield, Mo.

19. (a) Dec 18 39 (b) Wright
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 303 Shely St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17
year 1939 hour 9 - minute: 00 P. M.
21. I hereby certify that I attended the deceased from Nov 16
_____, 1939 to Dec 17, 1939
that I last saw h. alive on Dec 17, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Central Anasarca - apoplexy Duration 90da.
Due to Arteriosclerosis ?
Due to _____
Other conditions Diabetes Mellitus 6yr
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
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 _____
28. Signature Roy P. Haley (M. D. or other) MD
Address Brookfield Date signed 12/18/39

RECEIVED

District Health Officer No. 11;

District No. 149-1950

Date Recd. Jan 18 1948

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 H. B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, N.Y.

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.