

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. 563

Primary Registration District No. 6137

Registrar's No. 4

1. PLACE OF DEATH:
 (a) County Texas
 (b) City or town Rural
 (c) Name of hospital or institution: 2 Piney Swamp
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days most of life

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Texas
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Piney Swamp
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Tennessee Adeline Hane
 8. (b) If veteran, name war _____ 8. (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 John 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 23 1861
 (Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 12. Name unknown
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Hane
 (b) Address Pineville city Mo.

17. (a) Burial (b) Date thereof Jan 17 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Rayford V. Elliott
 (b) Address North to map 911

19. (a) 1-17-40 (b) Mabel Sheddell
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month JAN day 15
 year 1940 hour 12:15 minute 15 P. M.

21. I hereby certify that I attended the deceased from Aug 8 1937 to JAN 15 1940
 that I last saw her alive on JAN 14 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL APOPLEXY Duration _____

Due to HYPERTENSIVE CARDIO-RENAL-VASCULAR DISEASE

Due to _____

Other conditions SENILITY
 (include pregnancy within 3 months of death)

Major findings: 31 PHYSICIAN _____
 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 _____

23. Signature Rayford V. Elliott (M. D. or other) M.D.
 Address Lawton Date signed 1-16-40

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.

RECEIVED

District Health Officer No. 5,

District File Number 140 141

Date Filed 12-14-0

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.