

FILED MAR 14 1940

Registration District No. 334

Primary Registration District No. 4197

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Bethany
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Edna Lowell Fiore born

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James Fiore 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 2 1896
(Month) (Day) (Year)

8. AGE: Years 43 Months 9 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Harrison Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Oiver B Clinkenbeard

13. Birthplace Do not know (City, town, or county) (State or foreign country)

14. Maiden name Mary A Brown

15. Birthplace Harrison Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Fiore

(b) Address Bethany Mo

17. (a) Miriam (b) Date thereof 2-18-1940
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place of burial or cremation Miriam cemetery

18. (a) Signature of funeral director S. W. Has

(b) Address Bethany Mo

19. (a) 2-9-40 (b) A. L. Weising
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison
(c) City or town Bethany
(If outside city or town limits, write "RURAL")
(d) Street No. South 13 St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 6 year 1940 hour 2 minute _____ P. M.

21. I hereby certify that I attended the deceased from Feb 6 1940 to Feb 6 1940 that I last saw her alive on Feb 6 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 1/2 hrs

Due to _____

Due to ✓ § 2 V

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? 3 1/2 (Specify type of place) (e) Means of injury _____

28. Signature A. L. Weising (M. D. or other) _____

Address Bethany Mo Date signed 2-9-40

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1939-1-1

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.

RECEIVED
District Health Officer No. 10
District File Number 140-262
Date Filed MAR 6 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.....
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.