

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

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.

JUL 22 1940
Registration District No. **327**

Primary Registration District No. **5457**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Myers Gap, Oregon R.F.D.
(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 Lifetown _____
years, months or days 4 20

3. (a) PRINT FULL NAME ELSIE ELIZABETH HULSE

3. (b) If veteran, name war _____ 3. (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 Riley Hulse 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Aug 4 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>9</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles Baxter

13. Birthplace Penna
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Hulse

15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. Informant's own signature R. W. Hulse

(b) Address Osgood Mo R.F.D.

17. (a) Buried (b) Date thereof 6-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hall Park Mo

18. (a) Signature of funeral director W. K. Payne

(b) Address Salt Mo

19. (a) 6-1-40 (b) W. C. Weston
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. West of Osgood Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
year 1940 hour 7 minute 0 a. M.

21. I hereby certify that I attended the deceased from May 7 1940, to May 29 1940, that I last saw her alive on May 29 1940, and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic myocarditis - cerebral arteriosclerosis
Due to _____

Duration
5 year 7 year

Due to _____
Due to 92 C

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
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 W. C. Weston (M. D. or other) Reg.

Address Harris, Mo Date signed 6-2-40

RECEIVED

District Health Officer No. 117

District File Number 740-1126

Date Filed JUL 6 1940

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Halt

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.