

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. **213**

**FILED SEP 16 1940**

1. PLACE OF DEATH

(a) County **Callaway**  
(b) City or town **Fulton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **State Hospital # 1, Fulton**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **institution**  
(Specify whether  
In this community **1 yr 1 month 19 days**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Cooper**  
(c) City or town **BUNCETON**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **OK**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

**Annie Lut2 320**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **OK** 6. (c) Age of husband or wife if alive **D.K.** years

7. Birth date of deceased **MARCH 25 1857**  
(Month) (Day) (Year)

8. AGE: Years **83** Months **4** Days **0** If less than one day hr. \_\_\_\_\_ min.

9. Birthplace **INDIANA** (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **DON Mc Intyre**

13. Birthplace **GERMANY** (State or foreign country)

14. Maiden name **AMADINE Cooper**

15. Birthplace **INDIANA** (State or foreign country)

16. (a) Informant **State Hospital # 1 Records**

(b) Address **Fulton**

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

(c) Place: burial or cremation **Columbia mo**

18. (a) Signature of funeral director **J. O. Roberts**

(b) Address **Columbia mo**

19. (a) **Aug 27, 1940** (b) **R. N. Crewe**  
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **26**  
year **1940** hour **12** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **July 8**  
19**39** to **AUG. 26** 19**40**  
that I last saw h. **ER** alive on **AUG 26** 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Cerebral Thrombosis** **16 days**  
**Cerebral Arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death) **JA**

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?  
**1060** While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **J. O. Roberts** (M. D. or other) **!**  
Address **State Hospital No 1** Date signed \_\_\_\_\_

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

MOTHER FATHER

**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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**