

Registration District No. 604

Primary Registration District No. 4356

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
 (b) City or town Marion, Mo.  
 (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)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 3 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
 (c) City or town Marion  
 (If outside city or town limits, write "RURAL")  
 Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME LORINE WADDE

3. (b) If veteran, name war VI 3. (c) Social Security No. 2

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

6. (b) Name of husband or wife James Wadde 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 30 1917  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>10</u>	<u>11</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business  
 { 12. Name Perry Matt  
 13. Birthplace NY  
 14. Maiden name Marion Humphrey  
 15. Birthplace NY

16. (a) Informant's own signature Perry Matt  
 (b) Address Advance Mo

17. (a) Burial (b) Date thereof 1 FEB 40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation 2 mounds

18. (a) Signature of funeral director Wm O'Bannon  
 (b) Address Advance Mo

19. (a) 11-26-40 (b) Wm O'Bannon  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11  
 year 1940 hour 4 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Nov 7, 1940, to Nov 11, 1940;  
 that I last saw him alive on Nov 7, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Indigestion

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 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?  
5 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature Clara M. Ramey (M. D. or other) \_\_\_\_\_  
 Address Marion Mo Date signed 12/12/40

Duration 5 hours  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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.

1150

RECEIVED

District Health Officer No. 2,

District File Number 1240-172

Date filed 12/2/40

**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.

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.**