

Registration District No. _____

822 Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Shannon
 (b) City or town Eminee (Rural)
 (c) Name of hospital or institution: _____
 (If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days) 55 years 2

3. (a) PRINT FULL NAME Amelia Ann Orchard8. (b) If veteran, name war 8. (c) Social Security No. 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased March 31 1885
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
55 8 2 hr. min.9. Birthplace Shannon County
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Orchard13. Birthplace Alabama
(City, town, or county) (State or foreign country)14. Maiden name Melba Gault15. Birthplace Tenn
(City, town, or county) (State or foreign country)16. (a) Informant's own signature James Counts(b) Address Eminee17. (a) Funeral (b) Date thereof 11/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Chilton18. (a) Signature of funeral director W. H. Beckel(b) Address W. H. Beckel19. (a) 11-24-40 (b) Frank Hyde, MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Shannon
 (c) City or town Eminee (Rural)
 (If outside city or town limits, write "RURAL")

- (d) Street No. _____ (If rural, give location).
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
year 1940 hour 11 minute 30 P.M.21. I hereby certify that I attended the deceased from
Nov - 20, 1940, to Nov 23, 1940;
that I last saw her alive on Nov 22, 1940,
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Hemorrhage Duration _____

Due to _____

Due to _____

Other conditions _____
(Includes 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? Yes (Specify type of place) (e) Means of injury _____23. Signature Frank Hyde (M. D. or other) _____Address Eminee Date signed 11-24-40

RECEIVED

District Health Officer No. 5,

File Number 12401169

Received

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

J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address Day, Texas

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.