

Registration District No. 449

Primary Registration District No. 4267

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: MAIN STREET 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community my 5 mo 17 da years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE

(c) City or town LEBANON
(If outside city or town limits, write "RURAL")

(d) Street No. MAIN STREET OLD TOWN
(If rural, give location) 0

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME NORMA LEE FLAM

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased JUNE 20 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>5</u>	<u>17</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name IRVIN FLAM

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

14. Maiden name WYONA BENNETT

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

16. (a) Informant's own signature Norma Elam
(b) Address LEBANON MO

17. (a) BURIAL (b) Date thereof Dec 9 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO

18. (a) Signature of funeral director Roberts

(b) Address Lebanon Mo

19. (a) 1-9-41 (b) J. A. W. Lamb
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1941 hour 10 minute 20 P. M.

21. I hereby certify that I attended the deceased from 1-6-40
_____, 19____, to 1-7-40, 19____;
that I last saw her alive on 1-7-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature N. A. Hamilton (M. D. or other) 0

Address Lebanon, Mo. Date signed 1-8-40

Duration 2 days

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.

107

RECEIVED

District Health Officer No. 7,

District File Number 2-41-360

Date Filed 2-13-41

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 *W. Bahner*

Licensed Embalmer No. 1161

P. O. Address *Selmon Ave*

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3116

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH:

(a) County. Laclede
(b) City or town. Lebanon
(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 _____ (Specify whether _____)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME

Norma Lee Elam

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 7
year _____ hour _____ minute _____ M.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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

7. Birth date of deceased (Month) (Day) (Year)

Immediate cause of death

broncho pneumonia

8. AGE: Years Months Days If less than one day
1 6 17 hr. min.

Due to None

Due to _____

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 H. A. Hamilton (M. D. or other)

Address Lebanon, Mo. Date signed 4/10/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

