

FEB MAR 19 1941

Registration District No. **772**

Primary Registration District No. **4463**

Registrar's No. **1018**

74
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0

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

1. PLACE OF DEATH:

(a) County **St. Francois Co**
(b) City or town **Elvins, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1 City Randolph**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Francois**
(c) City or town **Elvins Mo 941**
(If outside city or town limits, write "RURAL")
(d) Street No. **City 3** (If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

3. (a) PRINT FULL NAME **Katherine Sue Layne**

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 **D**

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

7. Birth date of deceased **March 25 1940**
(Month) (Day) (Year)

8. AGE: Years **0** Months **11** Days **19** If less than one day **—** hr. **—** min.

9. Birthplace **Elvins Mo (D)**
(City, town, or county) (State or foreign country)

10. Usual occupation **—**

11. Industry or business **—**

MOTHER FATHER

12. Name **Clark Layne**
13. Birthplace **Elvins Mo (D)**
(City, town, or county) (State or foreign country)
14. Maiden name **Helen Hollen**
15. Birthplace **Elvins Mo (D)**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clark Layne**
(b) Address **Elvins Mo**

17. (a) **Burial** (b) Date thereof **2-16-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wood Lawn**

18. (a) Signature of funeral director **Sparks**
(b) Address **Elvins Mo**

19. (a) **2/16/41** (b) **C. Stover**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **14**
year **1941** hour **6** minute **30** AM.

21. I hereby certify that I attended the deceased from **Feb 11**, 19**41**, to **Feb 14**, 19**41**;
that I last saw her alive on **Feb 13**, 19**41**,
and that death occurred on the date and hour stated above.

Immediate cause of death **dumb**

Due to **Food poisoning (type unknown)**

Due to **—**

Other conditions (Include pregnancy within 3 months of death) **177**

Major findings: Of operations **111**

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? **—**

697 While at work? (Specify type of place) (e) Means of injury **—**

23. Signature **C. H. Hargrave** (M. D. or other) **MD**
Address **Flax River MO** Date signed **2-11-41**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 *Ernest Sparks*
Licensed Embalmer No. *2639*
P. O. Address *Evans Mo.*

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, fact should be so stated above.