

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

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution: **St Lukes Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **Nov 9-1941**
(Specify whether years, months or days) **6 Days**

3. (a) PRINT FULL NAME **Mrs. Ivon Egger**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NO**

4. Sex **fe** **5. Color or race** **W**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **E. F. Egger**

6. (c) Age of husband or wife if alive **3 1/2** years

7. Birth date of deceased **Dec 11 1913**
(Month) (Day) (Year)

8. AGE: Years **28** Months **11** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) **MO** _____ (State or foreign country) **O**

10. Usual occupation **House Wife**

11. Industry or business _____

12. Name **Dallas Howard**

13. Birthplace _____ (City, town, or county) **MO** _____ (State or foreign country) **O**

14. Maiden name **Elsie Hanagan**

15. Birthplace _____ (City, town, or county) **MO** _____ (State or foreign country) **O**

16. (a) Informant **Dallas Howard**

(b) Address **Highlandhill PhO R**

17. (a) Burial, cremation, or removal **Removal** **(b) Date thereof** **Nov 17 41**
(Month) (Day) (Year)

(c) Place: burial or cremation **Highlandhill mo**
at W. Maple

18. (a) Signature of funeral director **E. L. Crowe**

(b) Address **MO**

19. (a) 11-15-41 **(b) M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Christian**

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

(d) Street No. **Near Highlandhill**
(If possible, give location) **Star Route**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **15**
year **1941** hour **1** minute **50 P. M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Abscess**
Left Parietal

Due to **Not Determined** **12 1/2**

Other conditions **Congenital Heart Disease**
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **Brain Abscess**
(Autopsy limited to head)

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 **F. G. Carmichael M.D.** (M. D. or other) **O**

Address **Professional Bldg (Kerr)** **Date signed** **11/15/41**
Pandora, MO

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~~ _____

working under my personal supervision.

Registered Apprentice No. _____

Signed

Roy E. Snow

Licensed Embalmer No. *2560*

P. O. Address *Passaic City*

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.