

FILED FEB 13 1942
Registration District No. 876

Primary Registration District No. 6065 Paul

Registrar's No. 2

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Chaffee Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.F.D. #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 years, (Specify whether
In this community 26 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Chaffee Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #2 (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Lucinda Miller Patt
(b) If veteran, name war II (c) Social Security No. II

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 29th
year 1942 hour 10 minute 2 M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
7. Birth date of deceased: March 16 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-22, 1941, to 1-29, 1942
that I last saw him alive on 1-28-42, 1942
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>10</u>	<u>13</u>	hr. min.

Immediate cause of death: Poas abscess Duration 1 Month
Due to Carcinoma Caecum 1yr
Due to Carcinoma Uterus 3yr
Other conditions (Include pregnancy within 3 months of death)
Major findings: H&B
Of operations
Of autopsy

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

10. Usual occupation Housework

11. Industry or business II
12. Name Jacob Long
13. Birthplace No record, Indiana
(City, town, or county) (State or foreign country)
14. Maiden name No record
15. Birthplace No record
(City, town, or county) (State or foreign country)

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) (e) Means of injury _____

16. (a) Informant's own signature W. E. H. Hayes
(b) Address Chaffee Missouri, R.F.D. #2
17. (a) Burial (b) Date thereof 1-31-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenbrier Mo. Cem.

18. (a) Signature of funeral director W. E. H. Hayes
(b) Address 113 W. Oakum-Chaffee Missouri
19. (a) Jan 30th (b) Mrs. A. H. Davis
(Date received local registrar) (Registrar's signature)

23. Signature W. E. H. Hayes (M. D. or other) no
Address B. L. Bedy Chaffee Date signed 1/29/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORDS
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.

RECEIVED

District Health Office No. 2,

District File Number 2-42-156

Date Filed 2-10-42

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.