

FILED OCT 15 1942

Registration District No. 105

Primary Registration District No. 4177

Registrar's No. 11

1. PLACE OF DEATH: Dunklin
 (a) County Dunklin
 (b) City or town Charlton Charlton, Mo.
 (c) Name of hospital or institution: Home 1 Charlton Mo.
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Dunklin
 (c) City or town Charlton Mo.
 (d) Street No. _____
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME IDH. M. PIERCE
 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 Married
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec. 20 1890
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>9</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Mo. (City, town, or county) _____ (State or foreign country) 0

10. Usual occupation Teacher & Home wife

11. Industry or business _____

12. Name Wm. Manner
 13. Birthplace Mo. (City, town, or county) _____ (State or foreign country) 1
 14. Maiden name Jessie Brown
 15. Birthplace Mo. (City, town, or county) _____ (State or foreign country) 1

16. (a) Informant A. P. Pierce
 (b) Address Charlton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1942
 (Month) (Day) (Year)

(c) Place: burial or cremation Cape Miramon

18. (a) Signature of funeral director Landon Funeral Home
 (b) Address Campbell Mo.

19. (a) Oct. 5, 1942 (Date received local registrar) (b) L. Vonne Dunn (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4 year 1942 hour 10 minute 6 M.

21. I hereby certify that I attended the deceased from March - 1940 19____ to Oct. 4 1942
 that I last saw her alive on Oct. 4 - 1942 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure and
Chronic failure
 Due to Malignant Mediastinal tumor
 Duration 3 yrs

Other conditions (include pregnancy within 3 months of death) _____

Major findings: 478
 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? _____

While at work _____ (Specify type of place) (e) Means of injury 0

23. Signature Lomer Beale M.D.
 Address 110 N. Main Malden Mo. Date signed 10/5/42

35000
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1042-1260

Date Filed 10-6-42

581

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.