

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 139

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington RURAL St. Francois  
(c) Name of hospital or institution: Mo. State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 yrs. 3 mos. 17 das.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
(c) City or town Stoddard County Home  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALLIE MAY (ALLA MAE) HABADA

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife George Habada 6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years About 41 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife- Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James Stafford  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Tempy Grey  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4  
(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 11-9-42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Hospital Cemetery, Farmington, Mo.

18. (a) Signature of funeral director John A. Neidert  
(b) Address Farmington, Mo.

19. (a) 11-19-1942 (b) 3 yrs. dia. Buhmesth  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 9  
year 1942 hour 9 minute 10 A.M.

21. I hereby certify that I attended the deceased from November 9, 1942  
to November 9, 1942  
that I last saw her alive on November 9, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral pulmonary tuberculosis  
Due to \_\_\_\_\_

Other conditions Diphtheria  
(Include pregnancy within 3 months of death)

Major findings: Of operations 1381  
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) (Means of injury)  
23. Signature [Signature] (M. O. or other) \_\_\_\_\_  
Address Farmington, Mo. Date signed 11-18-42

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

94  
0  
0

94

0

0

0

0

Duration

8 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

1170

RECEIVED

District Health Officer No. 3  
District File Number 1242-1442  
Date Filed 12-8-42

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.....

No Embalming, Registered Apprentice No.....  
working under my personal supervision.

Signed John A. [Signature]

Licensed Embalmer No. 2238

P. O. Address Farmington

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.