

FILED MAR 14 1943

Registration District No. 144

Primary Registration District No. 5562

State File No.

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Bolet Knob

(c) Name of hospital or institution Home. arcadisa

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 34 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Elizabeth Marlow

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married 2 divorced. Widow

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 3 years (Month) (Day) (Year)

7. Birth date of deceased June 3 1860 (Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 13 If less than one day hr. min.

9. Birthplace Shannon Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

MOTHER FATHER { 12. Name Lesher

13. Birthplace Shannon Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Dora Knorr

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Zone Renschhausen

(b) Address Bolet Knob Mo

17. (a) Burial (b) Date thereof 2-17-43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bolet Knob Mo

18. (a) Signature of funeral director Spiegel & Co

(b) Address

19. (a) 2-16-43 (b) (Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Iron

(c) City or town Bolet Knob

(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 15 year 43 hour 4:30 minute

21. I hereby certify that I attended the deceased from Oct 16 1941 to Feb 15 1943 that I last saw her alive on Feb 9 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 5 yrs

Due to Arterial Sclerosis, general 10 yrs

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 93d

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Ben W. Bull (M. D. or other) M. D.

Address Ironton, Mo. Date signed 2-16-43

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

17
00

12 3 30

LIVED

District Health Officer No. 4
District File Number 343-1926
Date Filed 3-9-43

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. 4287

P. O. Address *Elwin*

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.