

2  
5-17-39  
X23139

State File No.

Registrar's No.

FILED JUL 12 1943  
Registration District No. 1943

Primary Registration District No. 4009

74

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town SAVANNAH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 20 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Savannah 2  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17  
year 1943 hour 8 minute PM M.  
21. I hereby certify that I attended the deceased from May 28  
1943 to June 17 1943  
that I last saw her alive on June 16th 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia Duration 2 wks

Due to depleity and lying in bed.

Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
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 Arthur H. Kelley (M. D. or other) \_\_\_\_\_  
Address Savannah Mo Date signed June 19, 1943

3. (a) PRINT FULLNAME Lydia Ann Heren

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 19 1856  
(Month) (Day) (Year)

8. AGE: Years 86 Months 10 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Morganico Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

12. Name Williams, Cook

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

14. Maiden name Emily Joy

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

16. (a) Informant Erle King

(b) Address Everston Del.

17. (a) B (b) Date thereof 6-18-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. C. Brack

(b) Address Savannah Mo

19. (a) 6-19-43 (b) A. H. Fitchman  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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.....

*E. C. Breit*

Licensed Embalmer No.....

*2650*

✓ P. O. Address.....

*Savannah 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.**

Jul 18 1943

State File No. \_\_\_\_\_

Registration District No. 2

Primary Registration District No. 4009

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Lavacum  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Lydia A. Green

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 19 1907  
(Month) (Day) (Year)

8. AGE: Years 36 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 June year 1943 M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_

that I last saw him \_\_\_\_\_ give on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above  
immediate cause of death hypersthenic stroke Duration \_\_\_\_\_

from cerebral

Due to \_\_\_\_\_

Due to debility & long

Other conditions in bed  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

WALSH

20703