

FILED OCT 19 1943

Registration District No. 43

Primary Registration District No. 5138

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Ellenore Rural Creek
(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.....
In this community.....
years, months or days (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler
(c) City or town Ellenore
(If outside city or town limits, write "RURAL")
(d) Street No. R#1
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country D

3. (a) PRINT FULL NAME

Linda Jay Roark

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
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased 6-23-1943
(Month) (Day) (Year)

8. AGE: Years 2 Months 2 Days 2 If less than one day hr. min.

9. Birthplace Peolar Bluff Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business.....

MOTHER FATHER { 12. Name Orville Roark
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Patey
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant One Oakley
(b) Address Ellenore Mo.

17. (a) Burial (b) Date thereof 9-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harmony, Mo.

18. (a) Signature of funeral director family in charge
(b) Address.....

19. (a) 9-21-43 (b) Belle Stinnie
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 20
year 1943 hour 9 minute 2 M.
21. I hereby certify that I attended the deceased from 8-15 1943 to 9-4 1943
that I last saw her alive on 9-4 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery
Duration 1 week

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death) 270

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 W. M. Lewis (M. D. or other)
Address Peolar Bluff Mo. Date signed 9-21-43

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

District
Date Filed

RECEIVED

District Health Office No.

District File Number 1043-42

Date Filed 10-15-43

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.....

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, fact should be so stated above.