No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 8 1943

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 39321

Registration District No. 341 Primary Registration District No. 61529 Registrar's No. 48

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

**1. PLACE OF DEATH:**

(a) County Stoddard

(b) City or town Rural Liberty Twp.
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Stoddard

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

(d) Street No. R. F. D. #4
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Lula Holwell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Colored 3

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug. (Month) 29 (Day) 1873 (Year)

8. AGE: Years 70 Months X Days 25 If less than one day hr. min.

9. Birthplace Little Rock (City, town, or county) Ark. / (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name I. G. Thomas
13. Birthplace (City, town, or county) Okla. / (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Julia Ayres
(b) Address Dexter R #4

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-43 (Month) (Day) (Year)
(c) Place: burial or cremation Dexter Colored Cem.

18. (a) Signature of funeral director Blankenship-Strickland
(b) Address Dexter, Mo.

19. (a) 11-20-43 (Date received local registrar) (b) Nora Smith (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct. day 24
year 1943 hour 10 minute X P. M.

21. I hereby certify that I attended the deceased from Unattended, to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to

Due to

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

Major findings:
Of operations
Of autopsy

Duration

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

23. Signature John Wilson (M.D. or other)
Address Bloomfield Mo. Date signed 11/9/43
County Doctor

1184

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1243-153
Date Filed 12-6-43

**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 J. E. Strickland

Licensed Embalmer No. 3479

P. O. Address Dusty, 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, above space should be left blank.**