

Registration District No. 1

Primary Registration District No. 4012

Registrar's No.

1. PLACE OF DEATH:

(a) County Atchison
 (b) City or town Rock Port
 (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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Atchison
 (c) City or town Rock Port
 (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 _____

3. (a) PRINT FULL NAME DR. LULA M. Mc KINNEY

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

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)
 7. Birth date of deceased Aug 24 1883
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 5 7 hr. _____ min.

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

10. Usual occupation Orthopedic

11. Industry or business _____
 MOTHER FATHER { 12. Name Ireland
 13. Birthplace Ohio (City, town, or county) (State or foreign country)
 14. Maiden name Miss Susanna Sumner
 15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Dr. P. H. Ireland
 (b) Address Harrison, Ia.

17. (a) burial (b) Date thereof Feb 2 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director Beth Ann Travel Home
 (b) Address Rock Port Mo

19. (a) Feb 1 1944 (b) Miss Hubert Townsend
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
 year 1944 hour 5:30 minute A.M.
 21. I hereby certify that I attended the deceased from Jan 30, 1944, to Jan 30, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 108

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings: Of operations _____
 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? _____
 (Specify type of place)
 While at work? _____ Means of injury 2
 23. Signature Dr. M. E. Redford (M. D. or other) D.O.
 Address Rock Port, Mo Date signed Jan 31 1944

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

105J

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.....

Frost A. Browning

Licensed Embalmer No.....

3238

P. O. Address.....

Tulsa, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.