

FILED FEB 8 1944 96
Registration District No. 2244 96

Primary Registration District No. 5335-5343

State File No. _____

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town Louisburg Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Shelton Hosp
(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 PERNIE CROLEY
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 Albert H Croley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 29 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Walnut Grove Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name William Healey
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Isabelle Tacker
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant A. H. Croley
(b) Address Louisburg Mo

17. (a) burial (b) Date thereof Dec 23 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn Buffalo

18. (a) Signature of funeral director L B Jones
(b) Address Buffalo Mo

19. (a) 2/3/44 (b) Wm R Davis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dallas³⁰
(c) City or town Louisburg Rural
(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 Dec day 17
year 1943 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Natural Causes
Duration _____

Due to _____

Due to _____

Other conditions _____
(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) (c) Means of injury _____

23. Signature L B Jones (M. D. or other) _____

Address Buffalo Mo Date signed Dec 17-43

1087

RECEIVED

District Health Officer No. 7,

District File Number 1-44-101

Date Filed 2-7-44

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 Marie B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo 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.

Registration District No. 94

Primary Registration District No. 348

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Louisburg, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Heart Hosp.
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Bernie Ashley

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 M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: Jan 29 1928
(Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days _____ If less than one day _____ min.

9. Birthplace _____ (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 April Day 7
year 1943 minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death: coronary thrombosis

Due to _____
Due to _____

Other conditions: _____ (Include pregnancy within 3 months of death) 94a

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 [Signature] (M. D. or other) _____
Address Buffalo Mo. Date signed _____

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

SUPPLEMENTAL

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