

FILED FEB 9 1944

Registration District No. 296

Primary Registration District No. 5944

Registrar's No. _____

1. PLACE OF DEATH

(a) County Phelps

(b) City or town St James - mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Soldiers Home Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year
(Specify whether years, months or days)

In this community 1 year
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Phelps

(c) City or town St James - mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME FLORENCE C. HERN

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

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

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

7. Birth date of deceased Dec 24 1860
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name Don't Know

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 Soldiers Home
(b) Address St James - mo

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

(c) Place: burial or cremation Soldiers Home cem

18. (a) Signature of funeral director W. E. Lichlicker
(b) Address St James - mo

19. (a) 1-24-1944 (b) Charles Beckwith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 12
year 1944 hour 2 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1944 to June 12 1944
that I last saw her alive on July 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Infection
Nephritis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy 12/0

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 0

23. Signature William H Brewer (M. D. or other) _____
Address St James mo Date signed 1/23/44

Duration 3 yrs

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

81
0
0

1091

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.....

me

....., Registered Apprentice No.

working under my personal supervision.

Signed

Orrel E. Licklider

Licensed Embalmer No. *3546*

P. O. Address *St James 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.