

FILED FEB 11 1944

Registration District No. **549**

Primary Registration District No. **4513**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Green Castle
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Green Castle
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether _____)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan

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

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Nora Leona Ledford

3. (b) If veteran, name war L

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1943 hour 6 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife George Ledford

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased 2 11 1871
(Month) (Day) (Year)

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of heart

Due to impregnation & septicemia

Due to _____

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

72 10 18 _____ hr. _____ min.

Duration _____

Other conditions (Include pregnancy within 3 months of death) patient has been blind for years

Major findings: _____

Of operations _____

Of autopsy 9504

9. Birthplace Sullivan Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John W. Steele

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Ball

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Geo W Ledford

(b) Address Green Castle Mo

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

(c) Place: burial or cremation Green Castle, Mo.

18. (a) Signature of funeral director Glenn E. Hunt, Son

(b) Address Green City, Mo.

19. (a) Jan. 29-48 (b) Laura Shaud, deputy
(Date received local registrar) (Registrar's signature)

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 Chas L. Judd (M. D. or other) Mo.

Address Parrott, Mo. Date signed Nov 29 43

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1351

Carroll W Sullivan Co.

RECEIVED
District Health Officer No. 10
District File Number 3-44-430
Date Filed FEB 10 1944

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 Archib W Wade
Licensed Embalmer No. 3037
P. O. Address Green City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Green Castle
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Nora S. Ledford
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 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 _____ years

7. Birth date of deceased Feb. 11 (Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Paula
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31-45 (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan. 28-44 (Date received local registrar) (b) Laura Shaw-Deputy (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 Dec Day 29 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

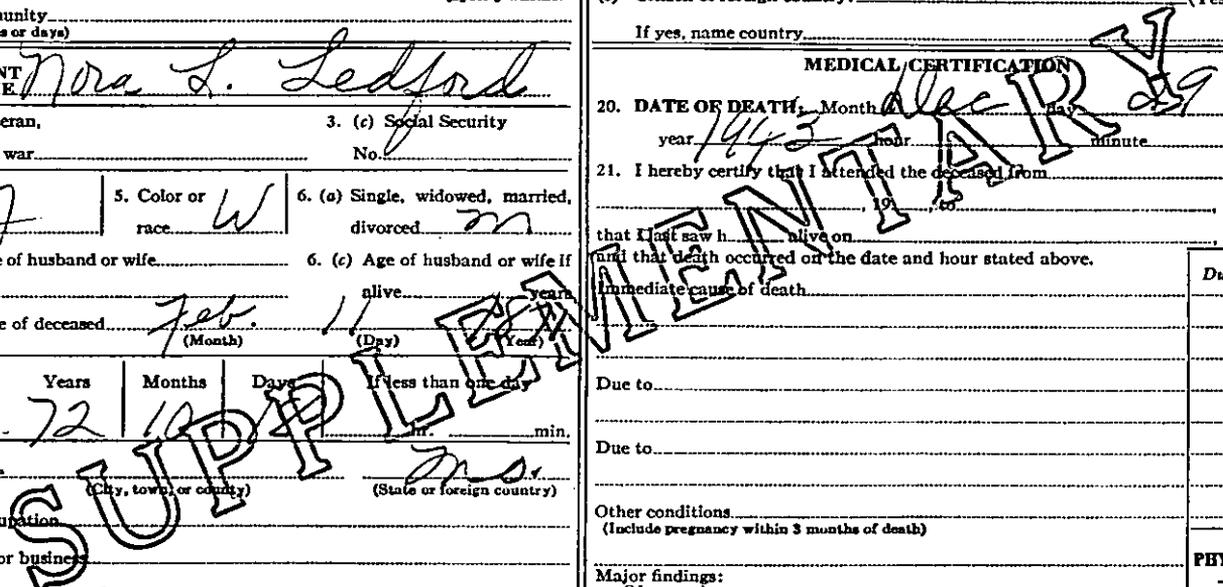
Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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



4697