

FILED MAR 11 1944
Registration District No. 27

Primary Registration District No. 5675-

1. PLACE OF DEATH:

(a) County: Lincoln
(b) City or town: Rural
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Hodassah Alexander

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: Single
6. (b) Name of husband or wife: None 6. (c) Age of husband or wife if alive: 1868
7. Birth date of deceased: Jan 1 1868

8. AGE: Years: 75 Months: 11 Days: 3 If less than one day .hr. .min.

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

10. Usual occupation: Housekeeper

11. Industry or business: Reid Alexander
12. Name: Reid Alexander
13. Birthplace: Kentucky
14. Maiden name: Sarah Jane Taylor
15. Birthplace: Lincoln

16. (a) Informant: Stella Alexander
(b) Address: Buscoe Mo.

17. (a) Burial (b) Date thereof: Jan 2 - 44
(c) Place: burial or cremation: Reid Cem.

18. (a) Signature of funeral director: Clifton Miller
(b) Address: Elkhart, Mo.

19. (a) Feb 8 1944 (b) G. B. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Lincoln
(c) City or town: Buscoe 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: December day: 31
year: 1943 hour: 10 minute: 50 P.M.

21. I hereby certify that I attended the deceased from 12/20 to 12/31, 1943,
that I last saw her alive on 12/30 - 1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Influenza
Due to: 5 days

Due to: 5 days

Other conditions: Lobar Pneumonia
(Include pregnancy within 3 months of death)

Major findings: Of operations: 33a
Of autopsy: 33a

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: J. B. Hoegh (M. D. or other) 24. D.
Address: W. B. Hoegh Date signed: 12/31 - 43

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-9-44

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 ^{not}.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.