

FILED MAR 14 1944

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. _____

1. PLACE OF DEATH

(a) County Peke Louisiana
(b) City or town Peke Louisiana
(c) Name of hospital or institution Peke Co Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 6 days
in this community 50 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MRS (CM) LILLIE CROW STARK

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Clarence M Stark 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased Feb 9 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 8 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business Home

12. Name alfred m bowell Crow

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

14. Maiden name Stark

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

16. (a) Informant Clay Stark

(b) Address Peke Louisiana Mo

17. (a) Burial (b) Date thereof 2-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverside - Louisiana Mo

18. (a) Signature of funeral director F. H. Harty

(b) Address Louisiana Mo

19. (a) 2-17-44 (b) Stark
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Peke
(c) City or town Louisiana
(If outside city or town limits, write "RURAL")
(d) Street No. 33 St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17 year 1944 hour 12 minute 10 A M

21. I hereby certify that I attended the deceased from Feb 9 1944 to Feb 17 1944

that I last saw her alive on Feb 16 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 3 days
Acute Cardiac Decompensation
Due to Intestinal Paralytic Ileus
Due to Chr. Bronchial Asthma 15 yrs
Chr. Arterio Sclerosis 15 yrs

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy 17782

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 Robert L. Hudson M.D. Date signed 2/17/44
Address Louisiana Mo

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

2
2
1

1169

RECEIVED

District Health Officer No. 10

District File Number 3-44-498

Date Filed MAR 8 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.....

George O. Wagner Registered Apprentice No.....
working under my personal supervision.

Signed George O. Wagner

Licensed Embalmer No. 3773

P. O. Address Louisiana, 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.