

FILED APR 7 1944
Registration District No. 3886

Primary Registration District No. 611213

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Illmo Rurah Rurak Twp
(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 About 2 Mo
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Scott Mo (b) County Scott 100
(c) City or town Illmo Rurak
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alice Marie Eads

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 baby

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

7. Birth date of deceased Jan. 28. 1944
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>1</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation ✓

11. Industry or business ✓

12. Name Illegimate

13. Birthplace ✓

14. Maiden name Wanda Lee Eads

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

16. (a) Informant Wanda Lee Eads

(b) Address Illmo. Mo. R1

17. (a) Burial (b) Date thereof May 21. 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation lightner Illmo, Mo

18. (a) Signature of funeral director Bisplinghoff Hubbard

(b) Address Illmo. Mo

19. (a) 3-21-44 (b) S. J. D. Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1944 hour 8 minute 10 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 Pneumonia

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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 Edgar Paul (M.D. or other)

Address Illmo. Mo Date signed 3/21/44

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 44-473

Date Filed 4-4-44

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. 3242

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. April
Registrar's No. _____

Registration District No. 330

Primary Registration District No. 6112 C

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Illmo Rural Kelso Twp.
(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

3. (a) PRINT FULL NAME Alice Marie Eads

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 S

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

7. Birth date of deceased Jan 28 1909
(Month) (Day) (Year)

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

9. Birthplace Mo.
(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 March year 1944 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 _____

Duration _____

Due to Bronchial

Due to h.m.i.d

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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