DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15085

State File No.

Registration District No. 175 Primary Registration District No. 4275 Registrar's No. 26

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Marionville
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence 55

(c) City or town Marionville 2 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Susan Lonena Hale

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 widowed

6. (b) Name of husband or wife A. S. Hale

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

7. Birth date of deceased July 15, 1866 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
77	7	17	hr. min.

9. Birthplace Weston, W. Va. / (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thos. J. Morris

13. Birthplace Trenton, N. Jersey / (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Lonena Bouse

15. Birthplace not known 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth D. Schumann

(b) Address Marionville, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-5-44 (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director J. B. Bradford

(b) Address Marionville, Mo.

19. (a) 3-5-1944 (Date received local registrar) (b) Eunice Greene by (Registrar's signature) atty

1156 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 3 year 1944 hour 11 minute 45 p. M.

21. I hereby certify that I attended the deceased from Jan. 1. 1944 to March 3. 1944 that I last saw her alive on March 3. 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Glomerular Nephritis	1 mo.
Due to Following Pneumonia	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury 2

23. Signature Wayne M. Weaver (M. D. or other) DO

Address Marionville, Mo. Date signed 3/5/44

APR 28 1944

RECEIVED
District Health Officer No. 6,
District File Number 444-492
Date Filed APR-13-1944

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 Herman M. Durr

Licensed Embalmer No. 3072

P.O. Address Aurora Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. MAY.

Registration District No. 175 Primary Registration District No. 4275 Registrar's No. 26

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Marionville
(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)

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

3. (a) PRINT FULL NAME Susan Lonena Hale

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 15 (Day) 1866 (Year)

8. AGE: Years 77 Months 7 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 3
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death acute glomerular nephritis — Duration 1 mo.

Due to Following pneumonia bronchial

Due to

Other conditions
(Include pregnancy within 3 months of death)

107

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Wayne M. Weaver (M. D. or other) D.O.

Address Marionville, Mo. Date signed

15085