

FILED MAY 12 1949

Registration District No. **259**

Primary Registration District No. **582-543.3** Registrar's No. **4356**

1. PLACE OF DEATH: **New Madrid**
 (a) County **New Madrid**
 (b) City or town **Parma**
 (If outside city or town limits, write "RURAL" and name of township)
 (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 **None**. (Specify whether
 In this community **50** years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **New Madrid**
 (c) City or town **Parma** (If outside city or town limits, write "RURAL")
 (d) Street No. **0** (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **1**

3. (a) PRINT FULL NAME **ELLEN, ANVILLE HUGHES**
 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 **divorced**
 6. (b) Name of husband or wife **Wm** 6. (c) Age of husband or wife if alive **18** years (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **12** year **1944** hour **2** minute **45 A.M.**
 21. I hereby certify that I attended the deceased from **Apr 10**, 1944 to **Apr 12**, 1944 that I last saw him alive on **Apr 10**, 1944 and that death occurred on the date and hour stated above.
 Immediate cause of death **Cardiac decomp**
 Duration

8. AGE: Years **76** Months **5** Days **24** If less than one day hr. min.
 9. Birthplace **Galanda Ill** (City, town, or county) **State 1** (State or foreign country)
 10. Usual occupation **Housewife**
 11. Industry or business
 12. Name **Columbus E. Holloway**
 13. Birthplace **Galanda Ill** (City, town, or county) **State 1** (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown** (City, town, or county) **9** (State or foreign country)
 16. (a) Informant **Wm Tom Sandre**
 (b) Address **Camp Mo. Rt 1**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Apr 14-44** (Month) (Day) (Year)
 (c) Place: **Bernie Mo**
 18. (a) Signature of funeral director **Walter J. S. Sauer**
 (b) Address **Parma, Mo**
 19. (a) **Apr 14/44** (Date received local registrar) (b) **Mrs S. B. Rademaker** (Registrar's signature)

Due to
 Due to
 Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations **gsc**
 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 **Quoted** (M. D. or other)
 Address **Parma Mo** Date signed **4/14/44**

MOTHER FATHER

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

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

RECEIVED

District Health Office No

District File Number 544-2

Date Filed 5-11-4

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

Embalmed

Registered Apprentice No

working under my personal supervision.

Signed

Hunter Albright

Licensed Embalmer No

4210

P. O. Address

S. Stanton

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.