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7-43  
7-39  
K37823

FILED MAY 23 1944

Registration District No. 23

Primary Registration District No. 6148

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard (c) Stoddard

(b) City or town R.F.D. Bloomfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Bloomfield Mo RFD #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3  
(Specify whether Life)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME Julia Ann Hastings

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 1

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Dec 18 1864  
(Month) (Day) (Year)

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

79 3 14 hr. min.

9. Birthplace Wattle Hill Bellvue Co.  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Jessie Beate

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

14. Maiden name Cady

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

16. (a) Informant Wm. Changman

(b) Address R.F.D. 2 Dikeston

17. (a) Burial (b) Date thereof 4-4-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berong Cemetery

18. (a) Signature of funeral director Wells Funeral Home

(b) Address Dikeston Mo.

19. (a) 4/10/44 (b) Pearl E. Moore  
(Date received local registrar) (Registrar's signature)

1130 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Bloomfield Mo RFD  
(If rural, give location)

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

If yes, name country — ID

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1  
year 1944 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from MARCH 16 1944 to APRIL 2 1944  
that I last saw her alive on MARCH 31 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death CANCER OF THE STOMACH Duration UNKNOWN

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions SENILE DEBILITY  
(Include pregnancy within 3 months of death)

Major findings: 468  
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: [Signature] (M.D. or other)

Address: BLOOMFIELD Date signed 4-3-44

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

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

MOTHER FATHER

RECEIVED

District Health Office No

District File Number 574-2

Date Filed 5-11-7

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 Raymond Clevs

Licensed Embalmer No. 3467

P. O. Address Stenton 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.