

FILED AUG 8 1944
Registration District No. **334**

Primary Registration District No. **6199**

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

1. PLACE OF DEATH:

(a) County **TEXAS**

(b) City or town **RURAL Clinton 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) **1**

(d) Length of stay: In hospital or institution **63 yrs** (Specify whether years, months or days)

In this community **63 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **TEXAS 107**

(c) City or town **RURAL**
(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 **0**

3. (a) PRINT FULL NAME **DELILAH CANADA**

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **19**
year **1944** 3 hour minute **A M.**

4. Sex **1 F** 5. Color or race **W**

6. (a) Single, widowed, married, divorced, **widowed**

6. (b) Name of husband or wife **JACK CANADA**

6. (c) Age of husband or wife if alive **6** years **1854** (Year)

7. Birth date of deceased **SEPT 6 1854**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 20 - 1944** to **July 19 - 1944**; that I last saw her alive on **July 18 - 1944** and that death occurred on the date and hour stated above.

8. AGE: Years **89** Months **10** Days **13** If less than one day hr. min.

Immediate cause of death **arteriosclerosis**

Duration

9. Birthplace **ANNA ILL**
(City, town, or county) (State or foreign country)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **HOUSEWIFE**

Major findings: **97**

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name **Elijah Hunt**

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

14. Maiden name **EMMA SIMMONS**

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

16. (a) Informant **Mrs. Law Johnson**

(b) Address **R # 4 Mill Brook SMO**

17. (a) **BURIAL** (b) Date thereof **July 23 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CANADA CEMETERY**

18. (a) Signature of funeral director **Raymond V. Elliott**
(b) Address **Carroll Mo.**

19. (a) **July 20 - 44** (b) **Mrs Lou Miller**
(Date recorded local registrar) (Registrar's signature)

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) (e) Means of injury

While at work

23. Signature **[Signature]** (M. D. or other)

Address **Mrs. Hunt Mo.** Date signed **7-20-44**

RECEIVED

District Health Officer No. 5

District File Number 844423

Date Filed 8-7-44

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Taylor Elliott*.....
Licensed Embalmer No. 2252
P. O. Address..... *Cabool MD*.....

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.