

Registration District No. 316 Primary Registration District No. 6075

1. PLACE OF DEATH: **St. Francois**

(a) County **rural Dunnington**

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **County Infirmary**

(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: **Viola E. Fohrell**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **I** 5. Color or race **W**

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

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

7. Birth date of deceased: **8/24/1897**

(Month) (Day) (Year)

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

47 **4** _____ hr. _____ min.

9. Birthplace: **Clinton Missouri**

(City, town, or county) (State or foreign country)

10. Usual occupation: **saleslady**

11. Industry or business _____

12. Name: **Henry Fohrell**

13. Birthplace: **Red Bud Illinois**

(City, town, or county) (State or foreign country)

14. Maiden name: **Loretta Mueller**

15. Birthplace: **Clinton Mo.**

(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Horace McLaren**

(b) Address: **Farlington, Missouri**

17. (a) (Burial, cremation, or removal) **burial** (b) Date thereof: **8/30/44**

(Month) (Day) (Year)

(c) Place: burial or cremation: **K. of P. Farlington, Und. Co.**

18. (a) Signature of funeral director: **Farlington, Mo.**

(b) Address _____

19. (a) **8-30-44** (Date received local registrar) **J. J. Phelps** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **Missouri St. Francois**

(a) State _____ (b) County _____

(c) City or town: **rural** **94**

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

(d) Street No.: **County Infirmary** **0**

(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **28**

year **44** hour **2:30** minute _____ P. M.

21. I hereby certify that I attended the deceased from **July** 19**44** to **Aug** 19**44**

I last saw him alive on **Aug** 19**44**

and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral Anoxia**

Duration: **7 yr**

Due to _____

Due to _____

Other conditions: **metastasis to lung**

(Include pregnancy within 5 months of death)

Major findings: **50**

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? _____

23. Signature: **N. O. Laube** (M. D. or other) **8/30/44**

Address: **Desloge Mo** Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1007

RECEIVED

District Health Officer No. 4
District File Number 944-4357
Date Filed 9-26-44

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.....

Licensed Embalmer No. 4084

P. O. Address Farmington 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.