

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

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:
A. S. O. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks
In this community Life 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. R. R. No. 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Edith B. True

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11
year 1944 hour 4:00 minute _____ P: _____ M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife William True

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Dec. 6 1899
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 13, 1944 to Oct 11, 1944.
that I last saw h. alive on Oct 11, 1944.
and that death occurred on the date and hour stated above.

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

52 10 5 hr. _____ min.

Immediate cause of death degeneration of liver

Due to secondary to gal. debility, anaesthesia & anemia

9. Birthplace Adair Co. 0 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Due to (Developed Perineal abscess also)

Other conditions Pruritus, anemia 5 yr
(Include pregnancy within 3 months of death)

MOTHER FATHER {

11. Industry or business _____

12. Name Isaac Stephens

13. Birthplace 0 Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Eva Leonard

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

Major findings: Hypertrophy, ant. callosity, permeability

Of operations _____

Of autopsy 12562

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

16. (a) Informant William True

(b) Address Novinger, Mo.

17. (a) Burial (b) Date thereof 10/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Novinger Cemetery

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? _____

18. (a) Signature of funeral director See Kelly
Kirkville, Mo.

(b) Address _____

19. (a) 10-30-44 (b) Mr. J. D. Wagner
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place)

(c) Means of injury 2

23. Signature Carl Laylie M. D. or other DO.

Address Kirkville, Mo. Date signed 10-21-44

286-1/44

1044

10-44-1761

NOV 3 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 J. E. Reilly

Licensed Embalmer No. 4181

P. O. Address Herknell 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.