

FILED OCT 28 1944

Registration District No. 218

Primary Registration District No. 4552

Registrar's No. 109

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

4  
1  
0

1. PLACE OF DEATH:

(a) County wright

(b) City or town Mountain Grove  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County wright 114

(c) City or town Mountain Grove 1  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Eliza Jane West

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 Married

6. (b) Name of husband or wife George West 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased November 12 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>74</u>	<u>9</u>	<u>17</u>		hr. _____ min. _____

9. Birthplace Wright County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Isaac Dodson

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Johns

15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant George West

(b) Address Mountain Grove Mo

17. (a) Burial (b) Date thereof 8/31/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hill-Crest Cemetery

18. (a) Signature of funeral director George Stapp

(b) Address Mountain Grove Mo

19. (a) H. M. Lower (b) 9-18-44  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29 year 1944 hour 11 minute 10 P.M.

21. I hereby certify that I attended the deceased from Aug 28 to Aug 29 1944 that I last saw h. g alive on Aug 28 and that death occurred on the date and hour stated above.

Immediate cause of death Infantile Parotiditis  
Admission to

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

Due to 468

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 0

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

Address [Address] Date signed 9/11/44

1333

1944

RECEIVED

District Health Officer No. 6,

District File Number 1044-1080

Date Filed OCT 18 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 George Shapp

8 Licensed Embalmer No. 3161

P. O. Address Mr. Sammie Mc

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.