

1. PLACE OF DEATH
 (a) County Caldwell
 (b) City or town Palo
 (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 all his life years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Caldwell
 (c) City or town Palo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Anna Mary Ireland
 3. (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov day 22
 year 1944 hour 9 minute 45 A.M.
 21. I hereby certify that I attended the deceased from Aug 5, 1944
 _____, 19____, to Nov 22, 19____
 that I last saw her alive on Nov 21, 19____
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race wh
 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: Oct 30 - 1858
 (Month) (Day) (Year)

Immediate cause of death Hodgkins disease
 Duration 14 Mo
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

8. AGE: Years 96 Months _____ Days 22 If less than one day _____ hr. _____ min.
 9. Birthplace: Caldwell Co MO
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy Hodgkins disease
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

10. Usual occupation _____
 11. Industry or business _____
 MOTHER FATHER { 12. Name Thos. Ireland
 13. Birthplace K. Y.
 (City, town, or county) (State or foreign country)
 14. Maiden name Martha Vincent
 15. Birthplace Tenn
 (City, town, or county) (State or foreign country)

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)
 While at work? _____ (e) Means of injury _____
 23. Signature C. H. Wilson M.D. (M. D. or other)
 Address Palo MO Date signed 11-22-44

16. (a) Informant Mrs Lucile Richards
 (b) Address Palo MO
 17. (a) Burial (b) Date thereof 11-23-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Prairie Ridge
 18. (a) Signature of funeral director Alexander's Chapel
 (b) Address Palo MO
 19. (a) Nov 22 44 (b) Corinne Garrett
 (Date received local registrar) (Registrar's signature)

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

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.....

P. O. Address.....

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.

Registration District No. 46

Primary Registration District No. 4065

Registrar's No. 67

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Oslo
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Anna M. Ireland
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Oct 30 (Month) (Day) (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation Substitute

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Nov 28 1944 (b) Corinne Larett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov Day 2 Year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

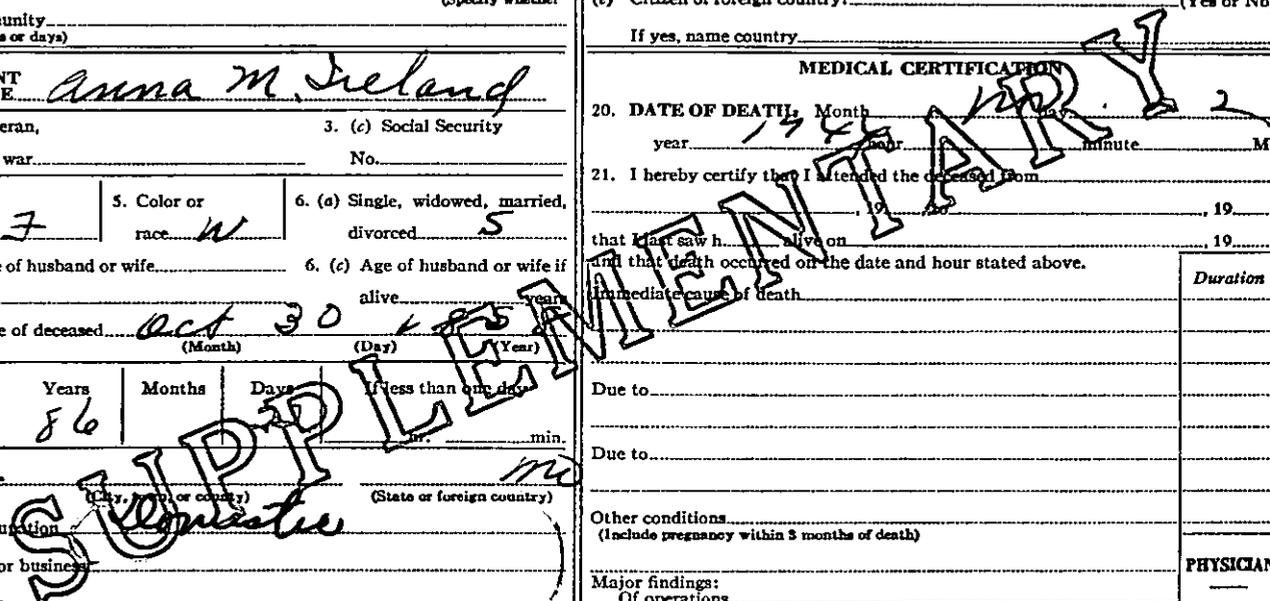
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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



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

MOTHER FATHER

37303