

FILED JAN 15 1945  
Registration District No. 76

Primary Registration District No. 4278

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

1. PLACE OF DEATH:

(a) County Lawrence Simons

(b) City or town Miller R.R.

(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 1 (Specify whether)

In this community Native years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town Miller R.R. 55 (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 Nancy M. Vaile

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 28 year 1944 hour 12 minute P. M.

4. Sex Female race white

5. Color or

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

6. (b) Name of husband or wife M. J. Vaile 6. (c) Age of husband or wife if alive 3 years (Month) (Day) (Year)

7. Birth date of deceased: 2 - 3 - 1880 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-26-44 1944 to 12-28-44 1944 ; that I last saw her alive on 12-26-44 1944 ; and that death occurred on the date and hour stated above.

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

64 10 25 hr. min.

Immediate cause of death Cerebral apoplexy

Due to Unknown to me

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

Due to

Other conditions (Include pregnancy within 3 months of death) 830

10. Usual occupation Housewife

Major findings: Of operations

11. Industry or business

12. Name Peter Olson

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

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

14. Maiden name Maud Bright

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

16. (a) Informant M. J. Vaile

(b) Address Miller Mo.

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?

17. (a) Burial (b) Date thereof 12-31-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Round Grove

While at work? (Specify type of place) (e) Means of injury

18. (a) Signature of funeral director Thomas Leman

(b) Address Miller Mo.

19. (a) 1-6-45 (b) Anna Whinery (Date received local registrar) (Registrar's signature)

23. Signature M. S. Beasley (M. D. or other)

Address Miller Mo. Date signed 12-29

RECEIVED

District Health Officer No. 6;

District File Number 145-26

Date Filed JAN 11 1945

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 *S. R. Leman*

Licensed Embalmer No. 3297

P. O. Address *Miller 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.