

FD-203
5-17-39
X36671

FILED JAN 4 1945

Registration District No. **181**

Primary Registration District No. **4273-567J-**

Registrar's No. **41**

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

1. PLACE OF DEATH:
 (a) County **Lincoln**
 (b) City or town **Elberney**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Rural**
 (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: **Emma Mae Warran**
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: **W**
6. (b) Name of husband or wife: _____ **6. (c) Age of husband or wife if** _____
7. Birth date of deceased: **March 21 - 1874**
 (Month) (Day) (Year)

8. AGE: Years - **69** Months **7** Days **2**. If less than one day _____ hr. _____ min.

9. Birthplace: **Nardin** (City, town, or county) **Ill.** (State or foreign country)

10. Usual occupation: **House wife**

11. Industry or business: _____

MOTHER FATHER
12. Name: **Henry H Rose**
13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name: **Mary Ann**
15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant: **Jessie Warran**

(b) Address: **Elberney**

17. (a) Burial, cremation, or removal: **Rural** **(b) Date thereof:** **Oct 29 - 44**
 (Month) (Day) (Year)

(c) Place: burial or cremation: **Oak Ridge**

18. (a) Signature of funeral director: **W. B. Bradley**

(b) Address: **Elberney**

19. (a) Date received local registrar: **Dec 6 1944** **(b) Registrar's signature:** **G. B. Williams**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Lincoln**
 (c) **Elberney Rural** (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 **Oct** day **27** year **1944** hour **1** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **June**, 19**43**, to **Oct 27**, 19**44**,
 that I last saw her alive on **Oct 26**, 19**44**,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of womb, liver & lower lobes of the lungs.** **Duration** **240**

Due to **Metastases**

Due to _____

Other conditions **48 1/2**
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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)
 (c) Means of injury **2**

23. Signature: **D. P. ...** (M. D. or other) **20**

Address: **Elberney, Mo.** **Date signed:** **11/1/44**

1193

RECEIVED

District Health Officer No.

District File Number

Date Filed 1-3-45

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 W. W. Bradley

Licensed Embalmer No. 3962

P. O. Address E. Perry

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 181

Primary Registration District No. (5675)

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Russell (Atchberg)
(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 _____
years, months or days

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 _____

3. (a) PRINT FULL NAME Emma M. Dawson

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 W

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: Mar 25
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) S. C. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day _____
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

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 _____

23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

41499