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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr Simmons.

State File No. 42267

FILED JAN 4 1945

Registration District No. 381

Primary Registration District No. 4515

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Milan
(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 1 (Specify whether
In this community 65 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105 1 0

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

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

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

3. (a) PRINT FULL NAME Bessie Lee Geasling

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F.W. 1

5. Color or race W

6. (a) ~~Single~~, widowed, ~~married~~, divorced 3 divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 7 (Day) 1879 (Year)

8. AGE: Years 65 Months 7 Days 1 If less than one day hr. min.

9. Birthplace Milan (City, town, or county) Mo 17 (State or foreign country)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name Thos Lane
13. Birthplace Front Royal (City, town, or county) Va 1 (State or foreign country)

MOTHER
14. Maiden name Nancy Frazier
15. Birthplace (City, town, or county) Ky 1 (State or foreign country)

16. (a) Informant Ethel Havermale
(b) Address Quincy Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-44 (Month) (Day) (Year)
(c) Place: burial or cremation Oakwood - Milan

18. (a) Signature of funeral director Schwene Funeral Serv.
(b) Address Milan Mo

19. (a) Dec. 2-44 (Date received local registrar) (b) Mrs. L. D. Greene (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8
year 1944 hour 8 minute P M.

21. I hereby certify that I attended the deceased from Sept the Twelfth 1944 to Nov. 8th 1944
that I last saw her alive on Nov. 8th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemmoragh. — Duration "Gives" mths.

Due to Hypertension.

Due to Dont know.

Other conditions
(Include pregnancy within 3 months of death) 83a

Major findings:
Of operations

Of autopsy None.

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?
(Specify type of place)
While at work? (e) Means of injury 3

23. Signature Dr. G. Simmons (M. D. or other) DO
Address Milan Mo. Date signed 11-18-44

11 7 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 13
District File Number 1-45-4
Date Filed JAN 3 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 Dwight Schoen

Licensed Embalmer No. 2667

P. O. Address Milan, 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.