

FILED FEB 2 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3144

Registration District No. 293

Primary Registration District No. 4436

Registrar's No. 100

1. PLACE OF DEATH:

(a) County RALL
(b) City or town NEW LONDON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: HOMES
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME

LULA FRANCIS SCOTT

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 WIDOWED
6. (b) Name of husband or wife ROY 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 25 1904
(Month) (Day) (Year)

8. AGE: Years 38 Months 7 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name JOSEPH H. REED
13. Birthplace OWENSKILLE KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name LIZZIE REED
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. MILDRED M. SHELLEY
(b) Address FORT KNOX KENTUCKY

17. (a) BURIAL (b) Date thereof 12-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BARTLEY CEMETERY

18. (a) Signature of funeral director JAMES O'DONELL

(b) Address Hannibal Mo

19. (a) 1-5-45 (b) R. S. BENTLEY
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RALL
(c) City or town NEW LONDON
(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 DEC day 27 year 1944 hour 2 minute 30.9 M.

21. I hereby certify that I attended the deceased from August 15, 1943 to Dec 26, 1944.
that I last saw her alive on Dec 26, 1944.
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Failure

Due to Concussions of lung

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 Eugene H. Hatcher (M. D. or other) DO
Address Two Haddon Mo Date signed 1-6-45

Duration

About 2 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

FEB 8 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.....

Michael J. Donnell

Licensed Embalmer No. *3246*

P. O. Address. *Hannibal 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 160

Registration District No. 293

Primary Registration District No. 4436

1. PLACE OF DEATH:

(a) County Rall
(b) City or town New London
(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)

3. (a) PRINT FULL NAME Lulu F. Scott

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 May 25
(Month) (Day) (Year)

8. AGE: Years 38 Months 7 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation housewife

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) IR S. BERKING
(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 Dec day _____
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him/her 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) _____

Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

3144

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