

FILED MAR 9 1945

State File No. _____

Registration District No. 117

Primary Registration District No. 4186

Registrar's No. 1

1. PLACE OF DEATH:

(a) County. FRANKLIN
(b) City or town. SULLIVAN
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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. MISSOURI (b) County. FRANKLIN
(c) City or town. SULLIVAN 56
(If outside city or town limits, write "RURAL") 8
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 5
year 1945 hour 7 minute 26 P.M.

21. I hereby certify that I attended the deceased from Dec 9 - 1944 to Jan 5 - 1945
that I last saw her alive on Jan 5 - 1945
and that death occurred on the date and hour stated above.

ImmEDIATE cause of death: Chronic mitral insufficiency with congestive failure and cardiac hypertrophy
Due to Rheumatic heart disease
Duration 2 years

Other conditions: arterial emboli - abdominal
(Include pregnancy within 3 months of death) 10 hours

Major findings: Of operations: _____
Of autopsy: 0/1/1
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 0

23. Signature: Ed. K. K. (M. D. or other) _____
Address: Sullivan Mo Date signed: 11/6/45

3. (a) PRINT FULL NAME LUVINIA HOUSTON

3. (b) If veteran, name war none 8. (c) Social Security No. none

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased AUGUST 30 1894
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 5 If less than one day hr. min.

9. Birthplace Iron County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Teaching

11. Industry or business School

12. Name Mrs. H. Henderson

13. Birthplace MADISON Co MO
(City, town, or county) (State or foreign country)

14. Maiden name SARAH ADAMS

15. Birthplace IRON Co MO
(City, town, or county) (State or foreign country)

16. (a) Informant THERESA HENDERSON
(b) Address BELGRADE MO

17. (a) BURIAL (b) Date thereof JAN 7, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SULLIVAN MO
(d) Signature of funeral director Thos. Hoffner
(e) Address Sullivan Mo

19. (a) 1/6/45 (b) Gilbert Gilhaus
(Date received local registrar) (Registrar's signature)

1121

(Licensed Embalmer's Statement on Reverse Side)

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

3640

MAR 12 1945

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 3-8-45

MAR 12 1958

JUL 19 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 Edgar W. Laffoon
Licensed Embalmer No. 2394
P. O. Address Sullivan 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, above space should be left blank.