

FILED FEB 21 1945

Registration District No. **316**

Primary Registration District No. **3059**

Registrar's No. **292**

1. PLACE OF DEATH:

(a) County **St. Francois**

(b) City or town **Bonne Terre**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **four weeks**
(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 **Washington**

(c) City or town **Belgrade**
(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.....

3. (a) PRINT FULL NAME **Mattie Louise Dane**

3. (b) If veteran, name war **no**

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **6**
year **1945** hour **3** minute **35 P.M.**

4. Sex **F** 5. Color or race **white**

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

6. (b) Name of husband or wife **Samuel Dane**

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

7. Birth date of deceased **July 3 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 10 - 44**
Jan 3 - 44 to **Jan 3 - 45**, 19.....
that I last saw him alive on....., 19.....
and that death occurred on the date and hour stated above.

8. AGE: Years **70** Months **6** Days **3**
If less than one day
hr. min.

Immediate cause of death.....
Myocardial degeneration 4 wks.
Carcinoma Uterus

Due to.....

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

10. Usual occupation **at home**

Due to.....

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

11. Industry or business.....

12. Name **Joshua Caffee**

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

14. Maiden name **Sarah Smith**

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

Major findings: **Carcinoma Uterus**

Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Hazel Smith**

(b) Address **Caledonia Mo.**

17. (a) **burial** (b) Date thereof **1-8-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Belgrade 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?.....

18. (a) Signature of funeral director **Norman White & Sons**

(b) Address **Ironton Mo.**

19. (a) **1-11-45** **Jarrest Plunson**
(Date received local registrar) (Registrar's signature)

(Specify type of place) (e) Means of injury.....

23. Signature **J.P. Plun** (M. D. or other)
Address **Jan 7 - 45** Date signed
Bonne Terre Mo.

1373

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

W.F. / 1 / 2 / 4

RECEIVED

District Health Officer No. 4

District File Number 245-251

Date Filed 2-20-45

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 Arnell J. White

Licensed Embalmer No. 2012

P. O. Address Houston, Tex.

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.