

FILED MAY 14 1945

Registration District No. _____

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Hubersville Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Erwin Smith D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community all her life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuyler
(c) City or town Rural (If outside city or town limits, write "RURAL") 94
(d) Street No. Near Downing Mo. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME BEAUFAN PEARL ALEXANDER

3. (b) If veteran: _____ name war _____ 3. (c) Social Security No. 2

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased April 12 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Henry Blain

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

14. Maiden name Mary Jane Reed

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

16. (a) Informant Frank Alexander

(b) Address Downing Mo.

17. (a) Rural (b) Date thereof April 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Downing Cemetery

18. (a) Signature of funeral director Lydia Moore

(b) Address Downing Mo.

19. (a) May 1 1945 (b) Mrs. J. W. Wagers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1945 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from April 25 1945, to April 28 1945 that I last saw her alive on April 27 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Staphylococci meningitidis (culture) Duration 4 days

Due to Cold or flu (?) not serious 10 days

Due to _____

Other conditions No other infectious source found
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: [Signature]
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) (e) Means of injury _____

23. Signature George E. Brown (M. D. or other) MD

Address Ficksville Mo Date signed 4-28-45

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

JUN 9 1945

RECEIVED

District Health Officer No. 10

District File Number 5-45-849

Date Filed MAY 10 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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed Loyd Moore

Licensed Embalmer No. 3151

P. O. Address Downing 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.