

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Rural, Freedom Twp.
(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 unnamed
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female! 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 29th 28th 1945
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Alvin S. Hutcheson
13. Birthplace Dunklin Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Earl Myrtle Malanp
15. Birthplace Dunklin Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Geo Hutcheson
(b) Address Clarkton, Mo. R.F.D.

17. (a) Burial (b) Date thereof 4/30/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lin Oak Cem.

18. (a) Signature of funeral director none
(b) Address _____

19. (a) April 29 1945 (b) LaVonne Deann
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dunklin Co
(c) City or town rural Freedom Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. 3 mi NE Clarkton
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 29th
year 1945 hour 10 minute 00 A. M.
21. I hereby certify that I attended the deceased from 4/29, 1945, to 4/30, 1945;
that I last saw her alive on 4/29, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Defective respiratory system - Duration _____
Due to Congenital
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy 158
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)
(a) Means of injury _____

23. Signature J. D. Stimmek (M. D. or other) MD
Address J. Clarkton Mo Date signed 4/30/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
Rev. 5-17-39 1 X1951

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1247

RECEIVED

District Health Office No. 2

District File Number 5451670

Date Filed 5-7-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.