S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13782

State File No.

Registration District No. 170

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 1 DAY
(Specify whether In this community 1 DAY
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County CAMDENTON
(c) City or town STOUTLAND 13
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? NO 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME THELMA ALEXANDER
3. (b) If veteran, name war
3. (c) Social Security No. 499-14-0741

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced MARRIED 1

6. (b) Name of husband or wife DORSEY ALEXANDER
6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased APR (Month) 22 (Day) 1915 (Year)

8. AGE: Years 30 | Months — | Days 6 | If less than one day hr. min.

9. Birthplace CAMDEN Co (City, town, or county) MO (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER FATHER
12. Name JOE JONES
13. Birthplace MILLER Co (City, town, or county) MO 0 (State or foreign country)
14. Maiden name OLLIE HOLSON
15. Birthplace CAMDEN Co (City, town, or county) MO 11 (State or foreign country)

16. (a) Informant Joe Jones
(b) Address STOUTLAND MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation LEBANON

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO

19. (a) May 1 45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR day 28
year 1945 hour 9 minute 5 A.M.

21. I hereby certify that I attended the deceased from 4/27, 1945 to 4/28, 1945 that I last saw her alive on 4/27, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: abortion	unknown
Due to: hemorrhage	unknown
Due to:	
Other conditions (Include pregnancy within 3 months of death) 1 4 hr	
Major findings: Of operations	
Of autopsy incomplete abortion 5 mo uterus with placenta.	

PHYSICIAN

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? (Specify type of place)
While at work? (e) Means of injury C

23. Signature James A. Hope, MD (M. D. or other)
Address Lebanon, Mo Date signed 4/28/45

1090 (Licensed Embalmer's Statement on Reverse Side)

Received ----------
Laclede County Health Unit
File No. 4-45-52
Date Filed 5/8/52

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 D. A. Palmer

Licensed Embalmer No: 1161

P. O. Address Lebanon

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.