

FILED JUN 14 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 4171

Registrar's No. 38

1. PLACE OF DEATH:

(a) County De Kalb
 (b) City or town Clarksdale ms.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 48 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Kalb
 (c) City or town Clarksdale ms.
(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 LILLIE A. BELCHER

3. (b) If veteran, name war _____ 3. (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 9 30 1955
(Month) (Day) (Year)

8. AGE: 90 Years Months Days If less than one day
 hr. min.

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

10. Usual occupation house wife

11. Industry or business _____

12. Name William Johnson

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

14. Maiden name Ada Combs

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

16. (a) Informant Jess Belcher

(b) Address Stewartsville, Rt 2

17. (a) Burial (b) Date thereof 5-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksdale ms.

18. (a) Signature of funeral director John J. Brown

(b) Address Stewartsville ms.

19. (a) 6-9-45 (b) John Clarke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7
 year 45 hour 2 P.m. minute _____ P. M.

21. I hereby certify that I attended the deceased from 1-4 1945 to 5-6 1945
 that I last saw her alive on 5-6 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Starvation

Due to Esophageal carcinoma

Due to _____

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

Major findings: Of operations 460

Of autopsy _____

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 _____

23. Signature Dr. Claude Tucker (M. D. or other)

Address Stewartsville Mo Date signed 5/8/45

Duration

7.7 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

69
2/28/81
1321
404
L
11

AUG 7 1945

RECEIVED
District Health Officer No. 111
District File Number
Date Filed

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 *John G. Brown*

Licensed Embalmer No. 393.3

P. O. Address *Waysville, 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.