

FILED AUG 14 1945

Registration District No. _____

Primary Registration District No. 3038

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Brookfield Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 11 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Laclede 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME VELMA LUTRAINNE MAHURIN

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 Married 1
6. (b) Name of husband or wife Husband Wm. Deville Mahurin 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased October 13 1904
(Month) (Day) (Year)

8. AGE: Years 40 Months 8 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Linn County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business own home

MOTHER FATHER { 12. Name Arthur K. Coates
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Eva Stoneker
15. Birthplace Linn County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant W.D. Mahurin
(b) Address Laclede, Mo.

17. (a) Burial (b) Date thereof 7-12-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Meadville, Mo. Cem

18. (a) Signature of funeral director M. D. Starn
(b) Address Laclede, Linn Co., Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1945 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from 7-1-45 to 7-9-45
that I last saw her alive on 7-9-45
and that death occurred on the date and hour stated above

Immediate cause of death Coronary embolism
19 hrs following
apoplexy + dysrhythmia
Due to Peritonitis (General) Duration 11 hrs

Due to Pneumia in origin probably
ruptured disintegration of sigmoid 12 hrs
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Large abscess in
lower left lung
Of autopsy None 129
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature B. B. Murch (M. D. or other) MD
Address Brookfield Mo Date signed 7-12

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

NOV 6 1952

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

W. S. Thamm

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

W. S. Thamm

Licensed Embalmer No. 2876

P. O. Address La Cade, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 184
Registrar's No. [Signature]

Registration District No. 184 Primary Registration District No. 3038

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(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

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

3. (a) PRINT FULL NAME Delma L. Mahurin
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 13 (Month) (Day) (Year)

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years 40 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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 _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) [Signature] (Registrar's signature)
(Date received local registrar)

23. Signature _____ (M. D. or other)
Date signed _____

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

SUPPLEMENTARY

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

S-24403