

FILED JUN 16 1945
Registration District No. 275

Primary Registration District No. 6100

Registrar's No. 32

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

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Salt River Township
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98

(c) City or town Rural Salt River Twp.
(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 Josephine Mc Elhinney

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 widowed

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

7. Birth date of deceased June 28 1859
(Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Schuyler Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER

12. Name Henry Myers

13. Birthplace not known _____
(City, town, or county) (State or foreign country)

14. Maiden name Lucinda Courier

15. Birthplace not known _____
(City, town, or county) (State or foreign country)

16. (a) Informant H. G. Mc Elhinney

(b) Address Green Top Mt.

17. (a) burial (b) Date hereof June 10, '45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fugate Cemetery

18. (a) Signature of funeral director Wm O. Chesb

(b) Address Lawrence City Mo

19. (a) June 10, 1945 (b) _____
(Date received local registrar) (a) Registrar's Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th
year 1945 hour 9:25 minute _____ M.

21. I hereby certify that I attended the deceased from 1940
_____ 19 _____ to 1945 19 _____

that I last saw her alive on June 8th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration _____

Due to _____

Due to _____

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

Major findings: 108

Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature L. R. Ellis MD (M. D. or other)
Address Riverview, Mo Date signed 6-8-45

RECEIVED

District Health Officer No. 10
District File Num. 7-45-1126
Date Filed JUL 13 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

....., Registered Apprentice No.
working under my personal supervision.

Signed

Wm H West

Licensed Embalmer No. 2882

P. O. Address. *Quincy 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.