

FILED AUG 30 1945

Registration District No. ...

Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone
(b) City or town COLUMBIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Fischel Stake Cancer Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether
In this community Ellis Fischel Stake
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Charles
(c) City or town St. Peters
(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 Adekine Linda Khire

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced M-1
6. (b) Name of husband or wife Leslen Khire 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 26 1910
(Month) (Day) (Year)

8. AGE: Years 34 Months 9 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

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)

16. (a) Informant Leslen Khire (Husband)

(b) Address St. Peters, Mo.

17. (a) Removal (b) Date thereof 7-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Mo

18. (a) Signature of funeral director Parkers

(b) Address Columbia Mo

19. (a) 7-7-1945 (b) Eolna H Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 7/2/45 to 7/6/45 that I last saw her alive on 7/6/45 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 2 days

Due to Carcinoma of Cervix with extensive metastasis (TMO)

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 480 Of autopsy As above
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 _____

Signature William T. Moran M.D. or other _____
Address Ellis Fischel Co. Hosp Date signed 7/6/45

1250

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

8/16-45

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: Thomas L. Lang

Licensed Embalmer No. 41132

P. O. Address: Columbia Md

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.