

No. 2
5-17-39
X36571

FILED AUG 30 1945

Registration District No. _____

Primary Registration District No. _____

5-419475-

State File No. _____

Registrar's No. _____

9

1. PLACE OF DEATH:

(a) County: Dunklin

(b) City or town: Hammersville Mo
(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: Mo (b) County: Dunklin

(c) City or town: Hammersville Mo
(If outside city or town limits, write "RURAL")

(d) Street No: Rural (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: DELLA HOLMES

3. (b) If veteran, name war: No 3. (c) Social Security No: 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: Jan 1 - 1886
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28
year 1945 hour _____ minute 30 P M.

21. I hereby certify that I attended the deceased from May 25 1945 to July 28 1945
that I last saw her alive on July 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis

Duration: _____

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>6</u>	<u>27</u>	hr. _____ min.

Due to _____

Due to _____

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

9. Birthplace: 2nd Prince Ark (City, town, or county) (State or foreign country)

10. Usual occupation: House wife

11. Industry or business: _____

12. Name: unknown

13. Birthplace: unknown 9 (City, town, or county) (State or foreign country)

14. Maiden name: unknown

15. Birthplace: unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant: Ray Holbro

(b) Address: Hammersville Mo #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: _____ (Month) (Day) (Year)

(c) Place: burial or cremation: Wape will emit

18. (a) Signature of funeral director: W.T. Emerit

(b) Address: Hammersville Mo

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

Major findings: _____

Of operations: _____

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? _____

23. Signature: Tan H. Bond (M. D. or other) _____
Address: Hammersville Mo Date signed: 7-28-45

(Specify type of place) _____ (c) Means of injury: _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2

District File Number 845-10

Date Filed 8-18-45

Handwritten notes and scribbles, possibly including the name 'John' and other illegible text.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 103

Primary Registration District No. 4175

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Somersville
(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

3. (a) PRINT FULL NAME Della Halmer

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 1 (Month) (Day) (Year)

8. AGE: Years 59 Months 6 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)

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) 7-29-45 (b) Linden B Perkins
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month _____ Day 28 Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____, _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

Due to _____
Due to _____

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

Major findings: 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 _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

5-27281