

FILED OCT 18 1945

Registration District No. 1

Primary Registration District No. 3400

Registrar's No. 219

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Grim-Smith Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____ (Specify whether _____)

In this community Live
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirkville
(If outside city or town limits, write "RURAL")

(d) Street No. 1003 W. Hildreth
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME George Lorraine

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Belle Lorraine

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov. 20 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>9</u>	<u>27</u>	hr. min.

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

10. Usual occupation Retired farmer

11. Industry or business _____

MOTHER FATHER

12. Name Arthur Lorraine

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

14. Maiden name Margaret Lorraine

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

16. (a) Informant Mrs. Anna Belle Lorraine

(b) Address Kirkville, Missouri

17. (a) Burial (b) Date thereof 9/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Novinger, Mo.

18. (a) Signature of funeral director D. E. Riley

(b) Address Kirkville, Missouri

19. (a) 9-24-45 (b) Mrs. J. P. Waynes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17th
year 1945 hour one minute 4.5 A.M.

21. I hereby certify that I attended the deceased from Aug 28, 1945, to Sept 17, 1945;
that I last saw him alive on Sept 16, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia

Duration 3 days

Due to Cerebral thrombosis Aug 9

Due to Heat exhaustion (?) Aug 8

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

Major findings: Of operations 944

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury D

23. Signature George E. Grinn (M. D. or other) MD

Address Kirkville, Missouri Date signed 9-17-45

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

1614

RECEIVED

District Health Officer No. 10

District File Number 10-45-156-7

Date Filed OCT 17 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 *D. W. Wiley*

Licensed Embalmer No. 4181

P. O. Address *Hicksville, 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.