S. No. 2
0M—2-43
v. 5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

PECK.

State File No. 34049

FILED OCT 17 1945

Registration District No. 170 Primary Registration District No. 8033 Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS (Specify whether years, months or days) In this community ALWAYS

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

3. (a) PRINT FULL NAME ELMIRA M. ALEXANDER
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 WIDOW
6. (b) Name of husband or wife T.L. ALEXANDER
6. (c) Age of husband or wife if alive years
7. Birth date of deceased SEPT (Month) 22 (Day) 1867 (Year)

8. AGE: Years 77 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace LACLEDE CO (City, town, or county) MO (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business

MOTHER / FATHER
12. Name WM MORGAN
13. Birthplace TENN (City, town, or county) (State or foreign country)
14. Maiden name NOT KNOWN
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Chas H Busby
(b) Address LEBANON
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 30 45 (Month) (Day) (Year)
(c) Place: burial or cremation BOLES CEM.
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) 9-7-45 (Date received local registrar) (b) Ora H. Frankeburger (Registrar's signature)

1463 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 28TH year 1945 hour 5 minute P M.
21. I hereby certify that I attended the deceased from 7/25/45, 19..., to 8/28/45, 19...; that I last saw her alive on 8/28/'45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	7 days
Due to: Cardio-renal vascular disease	1 mo. ??
Due to:	
Other conditions: Uremia (Include pregnancy within 3 months of death)	3 days

Major findings:
Of operations NONE
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

23. Signature John M. Beckham (M. D. or other)
Address Lebanon, Mo. Date signed 8/30/45

Received .....

Laclede County Health Unit

File No. 9-45-118

Date Filed 10/16/45

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 R A Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.