

FILED DEC 6 1945
Registration District No. 142

Primary Registration District No. 3376

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Mountain View
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community 68 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town Mountain View, Mo
(d) Street No. rural
(e) Citizen of foreign country? No
If yes, name country _____

3. (a) PRINT FULL NAME

Lora Ellen Thomas

(b) If veteran, name war None

(c) Social Security No. No

4. Sex F 5. Color or race W
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 October, 17th, 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months - Days 9
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name L.C. Bolerjack
13. Birthplace Illinois
14. Maiden name Lucy E. Jovner
15. Birthplace Illinois

16. (a) Informant Mrs L.L. Deboard

(b) Address Mountain View, Mo

17. (a) Burial Date thereof Oct 28, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Center Hill, Cem.

18. (a) Signature of funeral director John F. Duncan

(b) Address Mountain View, Mo

19. (a) Nov-10-45 (b) Laura Mitchell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26th
year 1945 hour 11 minute 30 p.m.

21. I hereby certify that I attended the deceased from Jan 1944 to 10-26-45
that I last saw her alive on Oct 1-45
and that death occurred on the day and hour stated above.

Immediate cause of death Sarcoma of Intestines
Due to Genital

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration _____

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? _____
(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 CR. Terrell (M. D. or other) _____
Address Mountain View, Mo. Date signed 11-24-45

1456

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 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 John J. Deaneau
Licensed Embalmer No. 2516
P. O. Address Montevideo 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DecRegistrar's No. 28Registration District No. 142Primary Registration District No. 5556

1. PLACE OF DEATH:

- (a) County Houma
 (b) City or town Rural
 (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 days3. (a) PRINT FULL NAME Lora E. Thomas

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 _____

7. Birth date of deceased
- Oct 17
-
- (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Day _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (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 CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw him _____ alive on _____, 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) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

37398