

No. 2  
8-43  
5-17-39  
X37823

State File No. \_\_\_\_\_

Registrar's No. 66

FILED DEC 27 1945  
Registration District No. 206

Primary Registration District No. 5749

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

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Rural Polk Township  
(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 Madison  
(c) City or town Rural (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 Lara Ruth Surman

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced U

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 13 1945  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 9 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Isaac W. Surman

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

14. Maiden name Lara May Surman

15. Birthplace Reynolds Co Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Bernel Surman

(b) Address Silver Mines

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation Silver Mines

18. (a) Signature of funeral director Webb Hall

(b) Address Fredericktown

19. (a) 11-6-1945 (Date received local registrar) (b) Florence Nickes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6 year 1945 hour 6 minute 15 M.

21. I hereby certify that I attended the deceased from Jan 13 1945 to Nov 6 1945 that I last saw him alive at his home and that death occurred on the date and hour stated above

Immediate cause of death Whooping Cough

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no  
(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 U

23. Signature M. B. Buehler (M. D. or other) \_\_\_\_\_  
Address Fredericktown Date signed 11/6/45

Duration \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4

District File Number 1245-1350

Date Filed 1-2-6-95

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**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 Webb - Holt.....

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.**