

FILED FEB 11 1946
Registration District No. **23**

Primary Registration District No. **5-113**

Registrar's No. **8**

1. PLACE OF DEATH:
 (a) County Bollinger
 (b) City or town Rural Union Twp
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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 Unknown (b) County 9
 (c) City or town _____ (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME ROSA LA SALLE
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 29
 year 1945 hour 6:00 minute P. M.

4. Sex F / 5. Color or race W
 6. (a) Single, widowed, married, divorced 9
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased _____
 (Month) (Day) (Year) 1900

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw or had care of 12/29/45 _____, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years 45 Months _____ Days _____ If less than one day
 hr. _____ min. _____

Immediate cause of death: Cerebral Hemorrhage
 Due to _____
 Due to _____

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

Other conditions Exposure
 (Include pregnancy within 3 months of death)
 Major findings: g30
 Of operations _____
 Of autopsy _____

10. Usual occupation Unknown

11. Industry or business _____

MOTHER FATHER
 { 12. Name Unknown
 { 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 { 14. Maiden name Unknown
 { 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Morley Swingle, Mo. State
 (b) Address Cape Girardeau, Mo.

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 3

17. (a) Burial (b) Date thereof Jan. 3, 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Litesville, Mo.

18. (a) Signature of funeral director Baker Funeral Home
 (b) Address Litesville, Mo.

19. (a) Jan 15, 1946 (b) Willie H. Daw Ansbury
 (Date received local registrar) (Registrar's signature)

23. Signature John H. M... Collins (M.D. or other)
 Address Litesville, Mo. Date signed 1/15/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
100069

Officer No. 4
File Number 246-168.8
Filed 2-7-46

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 *J. C. Graham*.....

Licensed Embalmer No. *4010*.....

P. O. Address *Luttrell, 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.**