S. No. 2
M—2-43
5-17-39
PI X35697

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

3582

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED MAR 8 1946

STANDARD CERTIFICATE OF DEATH

State File No. 4558

Registration District No. 32 — Primary Registration District No. 04450 — Registrar's No. 7

1. PLACE OF DEATH:
(a) County Bollinger
(b) City or town Lutesville, Francis Twp
(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 ____ In this community ____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Francois 94
(c) City or town Farmington 4
(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 Losta Rine Day
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex F | 5. Color or race Wh. | 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Dec 19 (Month) ____ (Day) 1855 (Year)

8. AGE: Years 90 | Months 1 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Jackson Co. (City, town, or county) W. Va (State or foreign country)
10. Usual occupation House Keeper
11. Industry or business ____

MOTHER FATHER
12. Name John L Rine
13. Birthplace ____ (City, town, or county) W. Va (State or foreign country)
MOTHER
14. Maiden name Clarissa Woodyard
15. Birthplace ____ (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Arnold Day
(b) Address Farmington, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 46 (Month) (Day) (Year)
(c) Place: burial or cremation Farmington, Mo
18. (a) Signature of funeral director Miller Funeral Home
(b) Address Farmington Mo
19. (a) Feb. 10, 1946 (Date received local registrar) (b) Willie Gail Ambrough (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5
year 1946 hour 8:30 minute P M.
21. I hereby certify that I attended the deceased from ____, 19__ to ____, 19__;
that I last saw her alive on 2/4/46, 19__;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Cardiac decompensation
Due to Hypostatic pneumonia
Due to ____
Other conditions (Include pregnancy within 3 months of death) V
Major findings:
Of operations ____
Of autopsy NO

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 [illegible] M.D. (or other)
Address [illegible] Date signed 2/11/46

25 (Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 4

District File Number 346-1820

Date Filed 3-2-46

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. E. Graham

Licensed Embalmer No. 4010

P. O. Address Statesville, N.C.

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.