

FILED APR 10 1946

State File No. _____

Registration District No. 18

Primary Registration District No. 4293

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Lincoln
(b) City or town Elsterry
(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 Lincoln
(c) City or town Elsterry
(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 _____

3. (a) PRINT FULL NAME Laura G. Birkhead
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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 25 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 7 23 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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

16. (a) Informant Mary Sweeney
(b) Address Elsterry

17. (a) Burial (b) Date thereof 3 20-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elsterry
18. (a), Signature of funeral director W. B. Bradley
(b) Address Elsterry

19. (a) 4/6/46 (b) Mrs. A. Switzer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 18 year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Feb 16 1946 to March 18 1946; that I last saw her alive on March 18 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 4 days
Due to Fracture left 8-9th rib

Due to Fall in home

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 E. Sweeney (M. D. or other) Med
Address Elsterry, Mo Date signed 3/20/46

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..... *W H Bradley*

Licensed Embalmer No..... *3966*

P. O. Address..... *Elberry*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. _____

Registration District No. 181

Primary Registration District No. 4293

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Elsberry
(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)

3. (a) PRINT FULL NAME

Laura G. Birkhead

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 and

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: July 25 (Month) (Day) (Year)

8. AGE: Years 90 Months 7 Days _____ (less than one day) hr. _____ min. _____

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

10. Usual occupation HOUSEWIFE

11. Industry or business

NONE

12. Name _____

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

14. Maiden name CLARRISSA GRIFFETH

15. Birthplace unknown MO. (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 July year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to FRACTURE RIBS
Due to FALL IN HOME

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

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Jul 14, 1946

(c) Where did injury occur? ELSBERRY, LINCOLN MO. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? IN HOME

While at work? NO (Specify type of place) (e) Means of injury FALL

23. Signature [Signature] (M. D. or other) _____

Address [Address] Date signed 7/12/46

SUPPLEMENTARY

HYDROSTATIC PNEUMONIA

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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