

10-2
M-8-43
v. 5-17-39
K37823

FILED APR 2 1946
Registration District No. 275

Primary Registration District No. 3053

Registrar's No. 59

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wm. Farland Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Crawford

(c) City or town Rural - Leasburg
(If outside city or town limits, write "RURAL")

(d) Street No. Route 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Grace D. Lieurance

3. (b) If veteran, name war Worlds #1

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar, day 18, year 1946 hour 5 minute 10 P. M.

4. Sex F / 5. Color or race wh

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Nov. 24 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 13, 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: Skull fracture

8. AGE: Years 62 Months 3 Days 24 If less than one day hr. min.

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

Due to _____

Due to _____

Other conditions Caecum of brain
(Include pregnancy within 3 months of death)

10. Usual occupation Nursing

11. Industry or business _____

12. Name Edwin Lieurance

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

14. Maiden name Arnette Wolfe

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant E. S. Lieurance - FE 14

(b) Address 116 1/2 Flat, Orange, Tex

17. (a) Removal (b) Date thereof March 20, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arlington Natl Cem

18. (a) Signature of funeral director Fuller

(b) Address Rolla Mo

19. (a) Mar. 19, 1946 (b) Mr. Juanita Harvey
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) Accident - car collision

(b) Date of occurrence 3-13-46

(c) Where did injury occur? near St James, Mo. 51
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place (Specify type of place) Highway 66
While at work? _____ (Specify means of injury)

23. Signature William M. Farland (M. D. or other) _____
Address Rolla, Mo. Date signed 3-19-46

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

MOTHER FATHER

APR 5 1948

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed S. L. V. [Signature]

Licensed Embalmer No. 3394

P. O. Address Rolla 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.