

FILED JUL 22 1946

Registration District No. 147

Primary Registration District No. 5552

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Koshkonong Myatt 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 _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell **46**
(c) City or town Koshkonong (Rural)
(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 Lucinda Meredith

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 Widowed

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

7. Birth date of deceased 1851
(Month) (Day) (Year)

8. AGE: Years 95 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Domestic

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Record

(b) Address _____

17. (a) Burial (b) Date thereof 6/6/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meredith Cemetery

18. (a) Signature of funeral director Wm. H. Weaver

(b) Address Wm. H. Weaver

19. (a) July 25, 1946 (b) Bladys Harrison
(Date required local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1946 hour 9 minute 30 P..M.

21. I hereby certify that I attended the deceased from 8-18-46 to 5-30-46, 1946

that I last saw him alive on 5-30-46 and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of Heart

Due to Serbia

Due to _____

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) _____
(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? _____

(e) _____ (Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature Wm. H. Weaver (M. D. or other) _____
Address Wm. H. Weaver Date signed 7/3/46

125 (Licensed Embalmer's Statement on Reverse Side) Weathers - Salt

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 6,
District File Number 746436
Date Filed 7-18-46

CO-10

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.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. augRegistration District No. 147Primary Registration District No. 5552

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Haskell
 (b) City or town _____
 (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 Lucinda meredith

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
- wid

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)

8. AGE:

Years

Months

Days

(if less than one day)

95

hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____

(Burial, cremation, or removal)

- (b) Date thereof _____

(Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a)
- July 25, 1946

(Date received local registrar)

- (b)
- Gladys Harrison

(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 _____

year 1946

hour _____

minute _____

M. _____

21. I hereby certify that I attended the deceased from _____

to _____

19 _____

that I last saw him alive on _____

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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.

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

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- (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 _____

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

Address _____

Date signed _____

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

SUPPLEMENTARY

23464