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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29444

FILED SEP 23 1946

Registration District No. _____

Primary Registration District No. 4001

Registrar's No. 366

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Nowinger
(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 none (Specify whether)
In this community Life (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Herachel C. Hanlin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MO 5. Color or race W 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: Mary 23 1915
(Month) (Day) (Year)

8. AGE: Years 31 Months 3 Days 2 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Charles R. Hanlin

13. Birthplace Adair Co Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mabel Felke

15. Birthplace Adair Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Charles R. Hanlin

(b) Address Nowinger Missouri

17. (a) Burial (b) Date thereof 8-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nowinger Missouri

18. (a) Signature of funeral director DEE Paley

(b) Address Starkville Mo

19. (a) 8-9-46 (b) State Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO, (b) County Adair
(c) City or town Nowinger 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1946 hour _____ minute _____ M.

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

Immediate cause of death: Epilepsy of brain Duration _____
Due to: 2.0 yrs Duration
Due to: _____

Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: 85 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:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence Aug 25 1946
(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? 3

While at work? _____ (Specify type of place) (c) Means of injury 3
23. Signature Forster R. Ensey (M. Deemer) Lambert
Address Brushy Mo Date signed 8-26-46

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

RECEIVED
District Health Officer No. 10
District File Number 946-1794
Date Filed SEP 23 1946

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.