

No. 2
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5-17-39
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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40130**
Registrar's No. **23**

Registration District No. **109** Primary Registration District No. **41805424**

1. PLACE OF DEATH:
(a) County **Dunklin**
(b) City or town **Wilhelmina**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **30 years** (years, months or days)

3. (a) PRINT FULL NAME **Lulu Green**
3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **January 28 1868**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 10 26 hr. min.

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

10. Usual occupation **Housework**

11. Industry or business _____

MOTHER FATHER
12. Name **Tom Kincaid** 9
13. Birthplace **unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Eva Gamble**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Wm T Green**
(b) Address **Wilhelmina Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-26-46** (Month) (Day) (Year)
(c) Place: burial or cremation **Wilhelmina**

18. (a) Signature of funeral director **Landess Funeral Home**
(b) Address **Campbell Mo**
19. (a) **Jan 2nd** (Date received local registration) (b) **Mrs. Buleh Campbell** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Dunklin**
(c) City or town **Wilhelmina**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** 24
year **1946** hour _____ minute **4:00 p.m.**
21. I hereby certify that I attended the deceased from **817**, 19**46**, to **12/23**, 19**46**; that I last saw her alive on **12/23**, 19**46**; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** Duration **5 mo +**
Due to _____
Due to _____

Other conditions **Bronchial Asthma** ?
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy **930**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Wallace Selsay** (M. D. or other) **Mo**
Address **Campbell Mo** Date signed **12/28/46**

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

RECEIVED
District Health Office No. 2,
District File Number 147-37
Date Filed 1-7-47

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.