

X32873

FILED JAN 22 1947

Primary Registration District No. 6152

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Bernie, Rural
(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.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stoddard
(c) City or town Rural #. F.
(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.....

3. (a) PRINT FULL NAME Nettie Marie Lamunio

3. (b) If veteran, name war X 3. (c) Social Security No. none

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Aug 1, 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 17 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Tuberculosis

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

14. Maiden name Bertha Lamunio

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

16. (a) Informant Bertha Lamunio

(b) Address Bernie, Mo.

17. (a) Burial (b) Date thereof 12 18 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bernie Cemetery

18. (a) Signature of funeral director Robert E. Orin
(b) Address Bernie, Mo

19. (a) 119-1947 (b) Lothie Jefferson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 18th
year 1946 hour 5 P.M. minute..... M.

21. I hereby certify that I attended the deceased from Aug 1, 1946 to Dec 16, 1946
that I last saw her alive on December 16, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to X

Due to X

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations X 107
Of autopsy X

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) X
(b) Date of occurrence X
(c) Where did injury occur? X
(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 2

23. Signature F O Kelley M.D.
Address Bernie, Mo. Date 12-21-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

357

(Licensed Embalmer's Statement on Reverse Side)

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

42500

RECEIVED

District Health Office No. 2

District File Number 147-72

Date Filed 1-13-47

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 *J. W. Schuman*
Licensed Embalmer No. 4086
P. O. Address *Malden*

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.