

FILED JAN 20 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 2

Primary Registration District No. 3009

Registrar's No. 1

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU.

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

(c) Name of hospital or institution:
SPRADLING NURSING HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4
(Specify whether years, months or days)

In this community 2 MONTHS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County STODDARD

(c) City or town ADVANCE
(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 ISABELLE GONNOR

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 month 13 day 1947
year 48 hour _____ minute _____ M.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased MAR. - 20 - 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-10-46 to 11-13-47
that I last saw her alive on 12/21/46 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Lung

8. AGE: Years 73 Months 9 Days 13
If less than one day hr. _____ min. _____

Due to _____

Due to _____

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

10. Usual occupation HOUSE WIFE

Other conditions MYOCARDITIS etc.
(Include pregnancy within 3 months of death)

11. Industry or business HOUSE WORK

MOTHER FATHER { 12. Name JOHN H. FREEZE

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

14. Maiden name MARY A LUKEN

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

Major findings: Of operations _____

Of autopsy 470

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. DAISY PARR

(b) Address CAPE GIRARDEAU MO

17. (a) BURIAL (b) Date thereof JAN 6 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation LORIMIER GEM

18. (a) Signature of funeral director Walthers Und. Soc

(b) Address Cape Girardeau, Mo

19. (a) 1-7-47 (b) D. S. Subur
(Date received local registrar) (Registrar's signature)

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

23. Signature [Signature] (M. D. or other) MD

Address Cape Girardeau Date signed 1/7/47

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

MAR 20 1947

RECEIVED

Sanitary Health Officer No. 4
Case File Number 147-76
Date Filed 1-15-47

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 Virgil H. Kelch
Licensed Embalmer No. 4102
P. O. Address Cape Girardeau - 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.