

Registration District No. **103**

Primary Registration District No. **5417**

1. PLACE OF DEATH:  
(a) County **DUNICLIN**  
(b) City or town **HORNERSVILLE, RFD #7**  
(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 **35 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO.** (b) County **DUNICLIN 35**  
(c) City or town **HORNERSVILLE, RURAL 2**  
(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 **LOU ALLEN EDWARDS**  
3. (b) If veteran, name war. (c) Social Security No.

4. Sex **FEMALE** 5. Color or race **WHITE**  
6. (a) Single, widowed, married, divorced **WIDOWED**  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased **FEBRUARY 14 1879**  
(Month) (Day) (Year)

8. AGE: Years **68** Months **0** Days **28**  
If less than one day **0** hr. **0** min.

9. Birthplace **RIPLEY TENN.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **HOUSE WIFE**

MOTHER FATHER

11. Industry or business  
12. Name **JIM ADKINS**  
13. Birthplace **TENN.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **SARAH SCRUGGS**  
15. Birthplace **UNKNOWN TENN.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Katie Edwards**  
(b) Address **Norcrossville, Mo.**  
17. (a) **BURIAL** (b) Date thereof **Mch. 13 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **HORNERSVILLE, MO**

18. (a) Signature of funeral director **H. Howard**  
(b) Address **Leachville Ark.**  
19. (a) **3-23-47** (b) **Bertha Kinsolving**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **MARCH** day **12** year **1947** hour **6** minute **A.M.**  
21. I hereby certify that I attended the deceased from **1/21/47** to **3/11/47**, 19 **47**  
that I last saw **her** alive on **3/11**, 19 **47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia** Duration **4 days**  
Due to **Cerebral Hemorrhage** **6 weeks**

Due to  
Other conditions (Include pregnancy within 3 months of death)

Major findings: **83A**  
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  
(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 **2**  
23. Signature **J. L. Keel, M.D.** (M.D. number) **00**  
Address **Hornersville, Mo.** Date signed **3/11/47**

RECEIVED

District Health Office N

District File Number 447-

Date Filed 4-8-

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..... *W. H. Howard*

Licensed Embalmer No. *3959*

P. O. Address *Leachville, Ark*

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.

Registration District No. 103

Primary Registration District No. 5417

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Rural  
(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 Law A. Edwards

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 and

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

7. Birth date of deceased Feb (Month) 1 (Day) 1944 (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

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

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) 3-23-1949 (Date received local registrar) (b) Bertha Kinschig (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 March 12  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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:

(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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

8509