

Registration District No. **91**

Primary Registration District No. **11040**

1. PLACE OF DEATH:

(a) County **Benton**
(b) City or town **Cole Camp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Moreland Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **8 Hours**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri **Benton**
(a) State _____ (b) County _____
(c) City or town **Cole Camp**
(If outside city or town limits, write "RURAL")
(d) Street No. **Moreland Clinic**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ruth Ann Lutjen**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** / **White** 5. Color or race **White**
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 _____
(Month) (Day) (Year)

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

9. Birthplace **Cole Camp Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name ~~**Harold Williams**~~

13. Birthplace ~~**Lincoln Missouri**~~
(City, town, or county) (State or foreign country)

14. Maiden name ~~**Lucile Lutjen**~~

15. Birthplace ~~**Benton County Missouri**~~
(City, town, or county) (State or foreign country)

16. (a) Informant **Charley Lutjen**

(b) Address **Cole Camp Mo**

17. (a) **Burial** (b) Date thereof **Aug 3 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cole Camp Cemetery**

18. (a) Signature of funeral director **E. L. Eickhoff**

(b) Address **Cole Camp Mo**

19. (a) **8-3-47** (b) **E. L. Eickhoff**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **2**
year **1947** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **8-2-47**, 19____, to **8-2-47**, 19____
that I last saw **her** alive on **8-2-47**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial Failure**
Due to **Cerebral Hemorrhage**

Due to _____

Other conditions (Include pregnancy within 8 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 **A. W. Moreland** (M. D. or other) **Doc**

Address **Cole Camp Mo** Date signed **8-3-47**

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

RECEIVED
District Health Officer No. 7
9-47-959
District File Number 8-13-47
Date Filed

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..... *E. L. Eckhoff*
Licensed Embalmer No..... 730
P. O. Address..... Cole Camp 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.