

FILED JUL 30 1947

Registration District No. **880**

Primary Registration District No. **4292**

Registrar's No. **44**

1. PLACE OF DEATH:
(a) County **LINCOLN**
(b) City or town **WINEFIELD**
(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 years, months or days)

3. (a) PRINT FULL NAME **NELLIE LOUISE JEANS**

8. (b) If veteran, name war **—** 8. (c) Social Security No. **—**

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

6. (b) Name of husband or wife **M.L. JEANS** 6. (c) Age of husband or wife if alive **DECEASED** years

7. Birth date of deceased **MAY 4 1862**
(Month) (Day) (Year)

8. AGE: Years **85** Months **2** Days **18** If less than one day hr. min.

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

10. Usual occupation **Housekeeper**

11. Industry or business

12. Name **JOHN LEWIS**

18. Birthplace **ENGLAND**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

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

16. (a) Informant's name **KENNETH JEANS**

(b) Address **4247^A Harris Ave - ST. LOUIS**

17. (a) **BURIAL** (b) Date thereof **7-24-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **HIGHLAND PRAIRIE**

18. (a) Signature of funeral director **Starbuck**

(b) Address **65 BERRY, MO**

19. (a) **7-23-47** (b) **P.C. Houselist**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **LINCOLN**
(c) City or town **WINEFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **—** (If rural, give location)
(e) If foreign born, how long in U. S. A. **—** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **22**
year **1947** hour **12** minute **20** P.M. C.S.T.

21. I hereby certify that I attended the deceased from **7-11**, 19**47** to **7-22**, 19**47**
that I last saw her alive on **July 22**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Paralysis (Hemiplegia)**
Due to **Arterial Sclerosis**

Other conditions (Includes 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) (e) Means of injury
23. Signature **P.P. Houselist** (M. D. or other)
Address **Old Monroe Mo** Date signed **7/24/47**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Date Filed 7-29-47
District File Number.....

District Health Officer No. B,
RECEIVED

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 O'Garland Riet

Licensed Embalmer No. 4012

P. O. Address Elsherry, 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, above space should be left blank.