

Registration District No. **218**

Primary Registration District No. **3054**

1. PLACE OF DEATH:

(a) County **Pike**
(b) City or town **Clarksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Pike County**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 d** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pike 82**
(c) City or town **Clarksville**
(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 **Catherine Douglas**

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

4. Sex **Female** 5. Color of race **Colored**
6. (a) Single, widowed, married, divorced **Wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Nov 30 1910**
(Month) (Day) (Year)

8. AGE: Years **36** Months **7** Days **15** If less than one day hr. _____ min. _____

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

10. Usual occupation **Housekeeper**

11. Industry or business _____

12. Name **Jefferson Douglas**

13. Birthplace **Clarksville** (City, town, or county) **Mo** (State or foreign country)

14. Maiden name **Lida Scott**

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

16. (a) Informant **May Frances R Allen**

(b) Address **Clarksville**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 18-47** (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **Harry L. Larree**

(b) Address **Clarksville** (c) **7-18-47** (Date received local registrar)

19. (a) **7-18-47** (Date received local registrar) (b) **Bernie Collins** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **15** year **1947** hour **12** minute **35P** M.

21. I hereby certify that I attended the deceased from **7-2** 19 **47** to **7-15** 19 **47**
that I last saw h. **er** alive on **7-15** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis**

Due to **Cerebral Thrombosis**

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **309**

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 home** (Specify type of place) (e) Means of injury _____

23. Signature **W. Cunningham** (M. D. or other) _____
Address **Clarksville** Date signed **7-17-47**

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

No. 2
5-43
5-17-39
1-234671

RECEIVED
District Health Officer No. 10
District File Number 8-47-1001
Date Filed AUG - 5 1947

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 George O. Hagner
Licensed Embalmer No. 3772
P. O. Address Louisiana, 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.

Registration District No. 218

Primary Registration District No. 3054

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

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisiana
(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 Catherine Douglas

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

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

6. (b) Name of husband or wife Reginald Kreis 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Nov. 30 (Month) (Day) (Year)

8. AGE: Years 36 Months 7 Days _____ (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Bernice Collier (Registrar's signature)

(Date received local registrar)

(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 _____ Year 1947 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. Duration _____

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

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 _____ (M. D. or other) _____
Date signed _____

S-25025