

7. S. No. 2  
 FORM-5-43  
 Rev. 5-17-39  
 I X36671

FILED AUG 19 1947

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 4024

Registrar's No. 81

1. PLACE OF DEATH:  
 (a) County Barry  
 (b) City or town Cassville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Purves Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Barry  
 (c) City or town Rural  
(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 Dorothy Le Compte  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 28  
 year 1947 hour 11 minute A. M.

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced, widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased February 21 1883  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 7 1947 to July 28 1947  
 that I last saw her alive on July 28 1947  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
64 5-- 7 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Pulmonary Tuberculosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Thurman LeCompte  
 (b) Address Cassville, Missouri

17. (a) Burial (b) Date thereof 8-1-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Maplewood Cemetery

18. (a) Signature of funeral director Culver Funeral Home  
 (b) Address Cassville, Missouri  
 19. (a) Aug 9 1947 (b) Grace Williams  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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)  
 Means of injury \_\_\_\_\_

23. Signature E. E. McDaniel (M. D. or Public Health Officer)  
 Address Cassville, Mo. Date signed 8/14/47

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

0-21

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 847-864

Date Filed AUG 19 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.....

A. F. Elkens

Registered Apprentice No. 495

working under my personal supervision.

Signed H. E. Culver

Licensed Embalmer No. 3584

P. O. Address Cassville

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.