

No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28198

National Office of Vital Statistics
FILED SEP 15 1947
Registration District No. 17

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 48 hrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53
(c) City or town Lebanon 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME INFANT DAUGH. OF JEWELL IVEY

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 6
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Aug. 7 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - 2 hr. min.

9. Birthplace Laclede Co. Lebanon Mo
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Jewell Ivey
15. Birthplace Laclede Co. Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Jewell Ivey Rhoden
(b) Address Lebanon, Mo.

17. (a) Burial (b) Date thereof 8-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W.E. Halstead
(b) Address Lebanon Mo

19. (a) Sept 6, 1947 (b) Dr. Frank Berger
(Date received local registrar) (Registrar's signature) 1520

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9
year 1947 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from Aug 7 1947 to Aug 9 1947
that I last saw her alive on Aug 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Premature infant Duration 2 days

Due to.....
Due to.....

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

PHYSICIAN
Major findings: 59
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 0

23. Signature James L. Hope M. D. or other.....
Address Lebanon, Mo. Date signed 9/2/47

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

MOTHER FATHER

Received 9/12/47
Laclede County Health Unit
File No. 8-47-143
Date Filed 9/13/47

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 _____
No Embalming _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.