

No. 2
5-43
5-17-39
1 X26671

FILED AUG 27 1947

279

Primary Registration District No. **5057**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If net in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
In this community About 85 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pike **82**
(c) City or town Eolia MO
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____
(If rural, give location) **0**
(e) Citizen of foreign country? no (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME Eliza Simmons

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

4. Sex Female 5. Color of race Dark 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased 1850
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>97</u>			hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name W. M. Douglass

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

14. Maiden name Swedish Hammer

15. Birthplace Pike Co (City, town, or county) (State or foreign country) MO

16. (a) Informant Benny Simmons

(b) Address Eolia MO

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

(c) Place: burial or cremation Eolia Col. Cemetery

18. (a) Signature of funeral director Norman E. Hoach

(b) Address Eolia MO

19. (a) Aug-16-1947 (Date received by local registrar) (b) NE Hoach Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug-14th day _____ year 1947 hour 12 AM minute _____ M.

21. I hereby certify that I attended the deceased from 9/17, 1946, to 5/3, 1947 that I last saw her alive on 12/18, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis

Due to Chronic myocardiosclerosis

Due to _____

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

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? 0

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature J. B. Hoeger (M. D. or other) MD

Address Whiteside MO Date signed 8/14/47

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

MOTHER FATHER

SEP 10 1988

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 Norman E. Yooch,

Licensed Embalmer No. 2342

P. O. Address Eolia 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Sept*

Registrar's No.

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

- (a) County *Pike*
 (b) City or town *Aud Prairieville*
 (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 *85 yr*
 years, months or days

3. (a) PRINT
FULL NAME*Elyia Seminaur*

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 *Wed*

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years *97* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation *Homemaker*

11. Industry or business _____

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) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *MO* (b) County *Pike*
 (c) City or town *Edelia*
 (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 _____ day _____
 year _____ hour _____ 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.
 Immediate cause of death _____

Duration

- Due to _____

- Due to _____

- Other conditions _____
 (Include 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?
 _____ (Specify type of place)

- While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

- Address _____ Date signed _____

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

SUPPLEMENTARY

S-28613