

FILED SEP 17 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 300

1. PLACE OF DEATH:

(a) County Ballaway
(b) City or town Ballaway
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital D-1, 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 52 years
(Specify whether
In this community same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Audrain
(c) City or town Tandalia
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

JOSEPHINE LAMING

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 W.

6. (b) Name of husband or wife D.K.

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

7. Birth date of deceased D.K.

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

D.K.

hr.

min.

9. Birthplace USA

(City, town, or county)

(State or foreign country)

10. Usual occupation Housework

11. Industry or business

12. Name D.K.

13. Birthplace D.K.

(City, town, or county)

(State or foreign country)

14. Maiden name D.K.

15. Birthplace D.K.

(City, town, or county)

(State or foreign country)

16. (a) Informant Peerday Hoopla

(b) Address Stanton

17. (a) Removal

(Burial, cremation, or removal)

(b) Date thereof 8-23-47

(Month) (Day) (Year)

(c) Place: burial or cremation Ballaway Mo

18. (a) Signature of funeral director H. P. Priso

(b) Address Tandalia Mo

19. Aug 23, 1947

(Date received local registrar)

J. H. Mankoff

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 22
year 1947 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from 8-16-47, 19 to 8-22-47, 19

that I last saw him alive on _____, 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death

1 of Abscess

Duration

Due to Abscess of the Parotid gland.

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)

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 D

23. Signature R. P. Priso (M. or other)

Address Quetta Mo Date signed 8/23/47

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 11 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 Wm. B. Yates
Licensed Embalmer No. 4169
P. O. Address Vandalia 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.