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-12-45  
-17-39  
X47070

FILED OCT 7 1947

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

Registration District No. 237

Primary Registration District No. 4496

Registrar's No. 91

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbyville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)

In this community 75 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby 102

(c) City or town Shelbyville  
(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 Olivia Carolina Lair

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Deceased

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

7. Birth date of deceased December 24th 1854  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 9th  
year 1947 hour 4 minute 45 P.

21. I hereby certify that I attended the deceased from Sept 4, 1947, to Sept 9, 1947  
that I last saw her alive on Sept 8, 1947  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>8</u>	<u>15</u>	hr. _____ min. _____

Immediate cause of death Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

10. Usual occupation House keeper

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

12. Name Hiram Burton Duncan

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

14. Maiden name Saline Massey

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

Major findings:  
Of operations an

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Emily Rostock

(b) Address St. Louis, Mo.

17. (a) Burial (b) Date thereof 9-11-1947  
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion Cemetery

18. (a) Signature of funeral director Million & Barklew

(b) Address Shelbyville, Mo.

19. (a) 9-30-47 (b) Ruth Jones  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_  
(a) Means of injury \_\_\_\_\_

23. Signature P. C. Brewer (M. D. or other) \_\_\_\_\_  
Address Shelbyville, Mo. Date signed 9-12-47

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 10  
District File Number 10-47-1363  
Date Filed OCT - 6 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.....

*James D. Davis*

....., Registered Apprentice No. *443*

working under my personal supervision.

Signed..... *W. Hawkins*

..... Licensed Embalmer No. *3498*

..... P. O. Address *Shelburne Vt*

**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.**