

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED NOV 28 1947

Registration District No. **1947/1**

Primary Registration District No. **4267**

Registrar's No. **16**

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

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Odessa**
(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 **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette**
(c) City or town **Odessa**
(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

3. (a) PRINT FULL NAME **Kate B. Haley**

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

4. Sex **Fe** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Mar 28 1869**
(Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **3** If less than one day hr. min.

9. Birthplace **Lafayette Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nurse**

11. Industry or business

12. Name **T.W. Lewis**

13. Birthplace **W. Va.**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Jeffers**

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

16. (a) Informant **Mrs. H.N. Brown**

(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 3, 1947**
(Burial, oration, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Odessa Mo. Cemetery**

18. (a) Signature of funeral director **Husman-Sparks**
Odessa, Mo.

(b) Address **Odessa, Mo.**

19. (a) **Aug 30-47** (b) **T. Letts**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **1**
year **1947** hour **1** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Feb 15 to Aug 1, 1947**
that I last saw her alive on **Aug 1, 1947**
and that death occurred on the date and hour stated above

Immediate cause of death **Hypertension - Delem-tomon**
Hypertension
Due to **Hypertension**
Due to **Arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death) **6 weeks**

Major findings: Of operations **935**
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?

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

23. Signature **R. C. Schaeley** (M.D. or other)
Address **Odessa MO** Date signed **8/1/47**

RECEIVED

Director Health Officer No. 8,

Date Filed 11-24-47

NOV 29 1947

DEC 3 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 Irving L. Husman
Licensed Embalmer No. 7541
P. O. Address Alton, 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.