

Registration District No. 4

Primary Registration District No. 4012

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Atchison Co
(b) City or town Rockport Mo
(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 3 yrs years, months or days

3. (a) PRINT FULL NAME Elizabeth Jane LAFLIN

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Sept 26 1873
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name James Yamble 4
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Atchison
15. Birthplace Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jean

(b) Address Rockport Mo

17. (a) burial (b) Date thereof Dec. 3 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Amesbury new cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Rockport Mo

19. (a) 12-1-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison 3
(c) City or town Rockport, Mo. /
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1,
year 1947 hour 8. minute 45 A. M.

21. I hereby certify that I attended the deceased from Nov. 27,
that I last saw her alive on Nov. 30 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic, lobar pneumonia. Duration 5 Dy

Due to Senility 5yrs

Due to _____

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

Major findings: Of operations _____
Of autopsy 108

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) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address Rockport Mo Date signed 12/1/47

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

W. E. Buttram....., Registered Apprentice No.....
working under my personal supervision.

Signed *W. E. Buttram*.....

Licensed Embalmer No. *1764*.....

P. O. Address *Rock Port, 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.