

Registration District No. 270

Primary Registration District No. 3033

Registrar's No. 22

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1  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Laclede

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

(c) Name of hospital or institution: Walpole O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 hrs.  
(Specify whether In this community 14 hrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Laclede

(c) City or town Lebanon mo 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 11 Cambridge Court  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bonnie Joe Quinn

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 1 year 1948 hour 1 minute 4 M.

4. Sex F 5. Color or race w

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Feb. 29 1948  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/29 1948, to 3/1 1948, that I last saw her alive on 2/29/48 and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 14 hr. min.

Immediate cause of death Cerebral hemorrhage Duration 1 hr.

9. Birthplace Lebanon mo. 1  
(City, town, or county) (State or foreign country)

Due to Prematurity

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

10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 8 months of death) \_\_\_\_\_

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

12. Name T. C. Quinn

13. Birthplace Lebanon mo. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Gene Rhoels

15. Birthplace Lebanon mo. 1  
(City, town, or county) (State or foreign country)

Major findings: 150

Of operations \_\_\_\_\_

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

16. (a) Informant T. C. Quinn

(b) Address Lebanon mo.

17. (a) Burial (b) Date thereof 3/12/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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 0

(c) Place: burial or cremation Lebanon

18. (a) Signature of funeral director Palmer

(b) Address Lebanon mo

19. (a) 3/12/48 (b) Theresa S. Lynch  
(Date received local registrar) (Registrar's signature)

23. Signature W. Carrigan M. D. or other M. D.

Address Lebanon, Mo. Date signed 3/15/48

Received 3/15/48

Department of Health Unit

File No. 3-48-34

Date filed 3/15/48

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

P. R. Palmer

Registered Apprentice No. 84

working under my personal supervision.

Signed P. R. Palmer

Licensed Embalmer, No. 2208

P. O. Address Seabrook Me.

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.