

FILED JUL 10 1948
Registration District No. **3/8**

Primary Registration District No. **6173**

Registrar's No. **49**

1. PLACE OF DEATH:
(a) County **Sullivan**
(b) City or town **Humphreys Mo Rural**
(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 **-**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Sullivan**
(c) City or town **Humphreys Mo Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **105**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country: **-**

3. (a) PRINT FULL NAME **ALTA INA ELWOOD**
3. (b) If veteran, name war: **-**
3. (c) Social Security No. **-**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **26**
year **1948** hour **-** minute **-** M.
21. I hereby certify that I attended the deceased from **1-1-48** to **6-26-48**
that I last saw her alive on **6-9-48**
and that death occurred on the date and hour stated above.
Immediate cause of death: **Carcinoma Liver**
Duration: **?**

4. Sex **Female** 5. Color or race **Wht**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Charles Elwood** 6. (c) Age of husband or wife if alive **-** years
7. Birth date of deceased: **Apr 5 1879**
(Month) (Day) (Year)

Due to **-**
Due to **-**
Other conditions (include pregnancy within 3 months of death) **-**
Major findings: **1164**
Of operations: **-**
Of autopsy: **-**
PHYSICIAN **-**
Underline the cause of which death should be charged statistically.

8. AGE: Years **69** Months **2** Days **21** If less than one day hr. **0** min. **0**

9. Birthplace **Macon Mo** (City, town, or county) (State or foreign country)
10. Usual occupation **House Wife**

MOTHER FATHER
11. Industry or business **-**
12. Name **Benjamin F Johnson**
13. Birthplace **Ky** (City, town, or county) (State or foreign country)
14. Maiden name **Sarah E Owens**
15. Birthplace **Va** (City, town, or county) (State or foreign country)

16. (a) Informant **Chas Elwood**
(b) Address **Humphreys Mo**
17. (a) **Rural** (b) Date thereof **6-28-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Humphreys Mo**

18. (a) Signature of funeral director **R. B. Galt**
(b) Address **Galt Mo**
19. (a) **July 6 48** (b) **Ereta Caldwell**
(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? **-** (Specify type of place)
While at work? **-** (e) Means of injury **-**
23. Signature **W. C. Westerman MD**
Address **Galt, Mo** Date signed **6-26-48**

RECEIVED

District Health Officer No.

District File Number 7-48-

Date Filed JUL 7 - 1949

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.....

P. K. Payne Jr

Licensed Embalmer No. 3450

P. O. Address.....

Galt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.