

FILED JUL 20 1948

Registration District No. **278**

Primary Registration District No. **3054**

Registrar's No. **82**

1. PLACE OF DEATH:
 (a) County **Pike**
 (b) City or town **Perrin**
 (c) Name of hospital or institution: **Pike County Hospital**
 (d) Length of stay: In hospital or institution **1 month**
 In this community **Life** years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Pike**
 (c) City or town **Perrin**
 (d) Street No. **Wehman Ave**
 (e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **MINNIE PEARL OUTHRIE**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

4. Sex **F** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **W**
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive **2 17 48** years

7. Birth date of deceased **2 17 48** (Month) (Day) (Year)
 8. AGE: **3 1/2** Years Months Days If less than one day

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

MOTHER FATHER
 11. Industry or business
 12. Name **Almy Outhrie**
 13. Birthplace **see!**
 14. Maiden name **Kathleen Taylor**
 15. Birthplace **Perrin**

16. (a) Informant **Mrs A. Outhrie**
 (b) Address **Louisiana, Mo**
 17. (c) **Burial** (b) Date thereof **7/8/48**
 (c) Place: burial or cremation **Riverview Cemetery**

18. (a) Signature of funeral director **Haley Mortuary**
 (b) Address **Louisiana, Mo**
 19. (a) **7-8-48** (b) **Bernice Collier**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **7** day **6** year **48** hour minute **94** M.
 21. I hereby certify that I attended the deceased from **6-8-48** to **7-6-48** that I last saw her alive on **7-6-48** and that death occurred on the date and hour stated above.

Immediate cause of death: **Malnutrition, Projectile Vomiting & convulsions 2 mo**
 Due to **Probable uterocervical hemorrhage** **3 1/2**
 Due to **Birth Injury** **mo**
 Other conditions: **hemiplegia - left** **1 wk.**
 (Include pregnancy within 3 months of death)

Major findings: Of operations **NO**
 Of autopsy

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?
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury **0**
 23. Signature **Chas H Lemellen** (M. D. or other)
 Address **Louisiana, Mo** Date signed **7-7-48**

RECEIVED

District Health Officer N

District No. *7-48*

JUL 19 1948

Dist. Filed

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

Geo. M. Collier

Licensed Embalmer No. *3839*

P. O. Address *Indepo*

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.