

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3019

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

1. PLACE OF DEATH:
(a) County DUNKLIN
(b) City or town KENNETT
(c) Name of hospital or institution: PRESNELL HOSPITAL
(d) Length of stay: 5 da
In this community 5 da years, months or days

3. (a) PRINT FULL NAME LUELLA HANNERS
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JAN. 15 1872
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 29
If less than one day _____ hr. _____ min.

9. Birthplace CAPE GIRARDEAU COUNTY, MO.
10. Usual occupation HOUSEWIFE

11. Industry or business _____
12. Name DAVID COOK
13. Birthplace UNKNOWN
14. Maiden name MIRIAH LONG
15. Birthplace UNKNOWN

16. (a) Informant JOHN HANNERS, JR.
(b) Address HORNERSVILLE, MO. RT. I
17. (a) BURIAL (b) Date thereof 8-15-48
(c) Place: burial or cremation BOY ELDER, LEACHVILLE, AR.
18. (a) Signature of funeral director Howard Funeral Service
(b) Address Leachville, Arkansas
19. (a) 8-21-1948 (b) Equal Husband
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County DUNKLIN
(c) City or town HORNERSVILLE RURAL
(d) Street No. _____
(e) Citizen of foreign country? NO

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month AUG. day 14th
year 1948 hour 12 minute 45 P. M.
21. I hereby certify that I attended the deceased from 8-10-48 to 8-14-48
that I last saw him/her alive on 8-14-48
and that death occurred on the date and hour stated above.

Immediate cause of death MYO-cardial heart disease
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
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) (e) Means of injury _____
23. Signature L.C. Wilson (M. D. or other) _____
Address Renewed, Mo. Date signed 8-20-48

RECEIVED

District Health Office No. 2,

District File Number 848-1052

Date Filed 8-23-48

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.