

Registration District No. 178 Primary Registration District No. 4284 Registrar's No.

1. PLACE OF DEATH:
(a) County LEWIS
(b) City or town LABELLE
(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 LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County LEWIS
(c) City or town LABELLE
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME MAUDE MILLS DANCE
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, widowed
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased: FEBRUARY 2 1880
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
68 - - - hr. 0 min.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 18 year 1948 hour minute M.
21. I hereby certify that I attended the deceased from
She was last seen alive 19... 19...
that I last saw her alive on May 15 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy
Duration
Due to: Found dead in her home May 25 1948
Due to: Previous attack of paralysis
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations: S30
Of autopsy: PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

9. Birthplace LABELLE MISSOURI
(City, town, or county) (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business
12. Name WESTERN F. MILLS
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name MARY ANN
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
16. (a) Informant Tom Mills
(b) Address Labelle Mo.
17. (a) BURIAL (b) Date thereof 5/26/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation LABELLE, MISSOURI
18. (a) Signature of funeral director: [Signature]
(b) Address Labelle Mo.
19. (a) 10-25-48 (b) G. H. JENNINGS, MD
(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) No signs of violence
(b) Date of occurrence
(c) Where did injury occur? At home, Labelle, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Bedroom of Residence, Labelle, Mo.
While at work? No (Specify type of place) (e) Means of injury: [Signature]
23. Signature: [Signature] (Date signed)
Address: Labelle, Mo.

RECEIVED

District Health Officer No. 11

District File Number 9-48-16

Date Filed SEP. 20. 1948

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

Charles L. Arnold, Jr.

Registered Apprentice No. *61*

working under my personal supervision.

Signed

J. A. Coder Jr.

Licensed Embalmer No. *4328*

P.O. Address

La Balle, 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.

Registration District No. 178 Primary Registration District No. 4284

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

1. PLACE OF DEATH:
(a) County Lewis
(b) City or town La Belle
(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 life years, months or days

3. (a) PRINT FULL NAME Maude M. Dance
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

7. Birth date of deceased: 7 mo 2 day 1948
(Month) (Day) (Year)
8. AGE: 68 Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Western F. Mills
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name Lucy Martin
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Tom Mills
(b) Address La Belle, Mo

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 5-26-48
(Month) (Day) (Year)

(c) Place: burial or cremation La Belle, Mo

18. (a) Signature of funeral director J. A. Coder
(b) Address La Belle, Mo

19. (a) Oct. 25 1948 (Date received local registrar) (b) Dr. P. W. Jennings, M.D. (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death: apoplexy

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? _____ (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: Earl H. Buckley, M.D. (M.D. or other)
Address: Canton, Mo Date signed _____

SUPPLEMENTARY 8

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

S-30291