

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 538

Primary Registration District No. 6230

Registrar's No. 94

1. PLACE OF DEATH:

(a) County Madison
 (b) City or town Bural (Miss La Motte)
(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

3. (a) PRINT FULL NAME Died unnamed
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 6 39
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>8</u> hr. <u>10</u> min.

9. Birthplace Madison Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 { 12. Name Chester Weston
 { 18. Birthplace Womack Mo
(City, town, or county) (State or foreign country)
 { 14. Maiden name Dora Virginia Reeves
 { 15. Birthplace Marquand Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Chester Weston
 (b) Address Miss La Motte Mo

17. (a) Burial (b) Date thereof 12/7/39
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Miss La Motte, Mo

18. (a) Signature of funeral director none
 (b) Address _____

19. (a) Dec 7 - 1939 (b) S. C. Slaughter
(Date received local registrar) (Registrar's Name)
By J. B. Sullivan

2. USUAL RESIDENCE OF DECEASED:

(a) State Same (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day sixth
 year 1939 hour 8:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Dec 6, 1939, to Dec 6, 1939
 that I last saw her alive on Dec 6, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Congenital weakness
 Due to Premature birth 6 1/2 mo
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
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Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

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 E. W. DeLaney (M. D. or other) D.O.
 Address Fredericktown Mo Date signed 12/6/39

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, above space should be left blank.