

**FILED**  
MAY 20 1940  
Registration District No. **677**

Primary Registration District No. **4403**

Registrar's No. **51**

1. PLACE OF DEATH

(a) County **Phelps**  
(b) City or town **Rolla**  
(c) Name of hospital or institution: **Rolla Hospital**  
(If not in hospital or institution, write street number & location) **1**  
(d) Length of stay: In hospital or institution **8 days**  
In this community **18 yrs**  
years, months or days

8. (a) PRINT FULL NAME **Laura M. Sewell**  
8. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **white**  
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 **9 - 8 - 1921**  
(Month) (Day) (Year)

8. AGE: Years **18** Months **6** Days **24**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **House work**

11. Industry or business \_\_\_\_\_

12. Name **William H Sewell**  
13. Birthplace **Phelps Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Madame E. Marshall**  
15. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **William H Sewell**  
(b) Address **St James Mo**

17. (a) **Burial** (b) Date thereof **4-4-1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove cem**

18. (a) Signature of funeral director **W. K. Richler**  
(b) Address **St James Mo**

19. (a) **April 4, 1940** (b) **Joe F. Myers**  
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Phelps**  
(c) City or town **Rural**  
(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 **April** day **2**  
year **1940** hour **10** minute **45** P. M.

21. I hereby certify that I attended the deceased from **March 25 - 1940** to **April 2 - 1940**  
that I last saw him alive on **April 2 - 1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Coronary Thrombosis**  
**Following appendectomy**  
**March 25, 1940**  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **acute appendicitis**

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?  
**610** (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **William H Sewell** (M. D. or other) \_\_\_\_\_  
Address **St James Mo** Date signed **4/4/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

81  
2  
1

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

*Cross E. Licklider*

Licensed Embalmer No. 3546

P. O. Address St James

RECEIVED

District Health Officer No. 5

District File Number 540 591

Date Filed 5-12-40

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.