

FILED APR 15 1942
Registration District No. 688489

Primary Registration District No. 3033

Registrar's No.

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

1. PLACE OF DEATH: *Pike*

(a) County *Louisiana*

(b) City or town *Louisiana*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *at home 912 Iowa St*
(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 *Mrs (HC) Ada Trower*

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 *married*

6. (b) Name of husband or wife *Clint Trower* 6. (c) Age of husband or wife if alive *65* years

7. Birth date of deceased *Feb 2 1874*
(Month) (Day) (Year)

8. AGE: Years *68* Months *10* Days *1* If less than one day _____ hr. _____ min.

9. Birthplace *Rural Bowling Green Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation *Home*

11. Industry or business *Home*

MOTHER FATHER { 12. Name *M Dellender*

13. Birthplace *Louisiana*
(City, town, or county) (State or foreign country)

14. Maiden name *Frances Ellen Harris*

15. Birthplace *Rt 2 Louisiana Mo*
(City, town, or county) (State or foreign country)

16. (a) Informant *Clint Trower*

(b) Address *Louisiana Mo*

17. (a) *Burial* (b) Date thereof *3-5-42*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Riverside Cemetery*

18. (a) Signature of funeral director *A. H. Hays*

(b) Address *Louisiana Mo*

19. (a) *3/3/42* (b) *A. H. Hays*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: *82*

(a) State *Mo* (b) County *Pike*

(c) City or town *Louisiana*
(If outside city or town limits, write "RURAL")

(d) Street No. *912 Iowa St*
(If rural, give location)

(e) If foreign born, how long in U. S. A.? *0* years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* day *3*
year *1942* hour *1* minute *30 P* M.

21. I hereby certify that I attended the deceased from *March 3/42*
only 19____ to 19____
that I last saw *her* alive on *March 3* 19____
and that death occurred on the date and hour stated above.

Immediate cause of death *angina pectoris*

Duration _____

Due to _____

Due to _____

Other conditions *94 b*
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
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 *A. E. Bilgus* (M. D. or other) *DO*
Address *Louisiana Mo* Date signed *3/3/42*

RECEIVED

District Health Officer No. 10

District File Number 4-10-752

APR 14 1942

Date 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.....

George O. Hagner

Registered Apprentice No.....

working under my personal supervision.

Signed *George O. Hagner*

Licensed Embalmer No. 3773

P. O. Address Louisiana 7

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.