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

1. PLACE OF DEATH:

(a) County Hurdland (Rural)

(b) City or town Shelton Gap  
(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 17 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Knox

(c) City or town Hurdland (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.

3. (a) PRINT FULL NAME L. O. M. Stice

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30  
year 1942 hour 2:45 minute \_\_\_\_\_ A.M.

4. Sex F.

5. Color or race W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Samuel Stice

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 2 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 18, 1942, to April 23, 1942, that I last saw her alive on April 27, 1942, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>11</u>	<u>30</u>	hr. _____ min. _____

Immediate cause of death Cardiac Failure

Due to Exophthalmic goiter 20 yrs

Due to \_\_\_\_\_

9. Birthplace Bible Grove Mo  
(City, town, county) (State or foreign country)

10. Usual occupation Housewife

Other conditions Owner of the uterus 5 yrs  
(Include pregnancy within 3 months of death)

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

12. Name Samuel Tremaine

13. Birthplace \_\_\_\_\_  
(City, town, county) (State or foreign country)

14. Maiden name Martha Ann Arnold

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy HJB

16. (a) Informant Lester E. Stice

(b) Address Hurdland Mo

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof: 4-30-42  
(Month) (Day) (Year)

(c) Place: burial or cremation Bible Grove

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? \_\_\_\_\_

18. (a) Signature of funeral director Mrs. J. W. Hurdson

(b) Address Edina Mo

19. (a) April 30 1942  
(Date received local registrar)

(b) W. H. Northcutt  
(Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature Wm. W. Klesser (M.-D. or other) \_\_\_\_\_

Address Hurdland Mo Date signed Apr. 30 1942

RECEIVED

District Health Officer No. 10

District File Number 5-42-968

Date Filed MAY 13 1942

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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 Mrs J. W. Hudson

Licensed Embalmer No. 2972

P. O. Address Edina 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.