

APR 15 1943
Registration District No. **100**

Primary Registration District No. **5390**

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

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.

1. PLACE OF DEATH:
 (a) County Dent
 (b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1 Spring Leach, Tenn
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 33 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Elin Effrosune Stevens
 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 W
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive years _____
 7. Birth date of deceased March 17 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>0</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace Finland 4
(City, town or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER
 12. Name Carl Kinnunen
 13. Birthplace Finland 4
(City, town or county) (State or foreign country)
 14. Maiden name Katharine Pasanen
 15. Birthplace Finland 4
(City, town or county) (State or foreign country)

16. (a) Informant's own signature Katherine Kussman
 (b) Address Rt 1 Box 18, Salem, Mo

17. (a) Burial (b) Date thereof 3-31-43
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wafford

18. (a) Signature of funeral director Robert Gault
 (b) Address Salem, Mo

19. (a) 3-30-43 (b) J. D. [unclear]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Dent **33**
 (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.? 41 years **0** years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 27
 year 1943 hour 10 minute 45 P.M.
 21. I hereby certify that I attended the deceased from 10-10, 1942, to 3-27-43, 1943;
 that I last saw her alive on 3-15-43, 1943;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery disease
 Due to arteriosclerosis
hypertension
 Other conditions 94
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

Duration unknown

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 J. D. [unclear] (M. D. or other) D.O.
 Address Salem, Mo Date signed 3-30-43

RECEIVED

District Health Officer No. 5

District File Number 443241

Date Filed 4.12-43

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 Hayd W. Fox
Licensed Embalmer No. 2910
P. O. Address Salem 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, above space should be left blank.