

FILED APR 7 1945
Registration District No. 1940

Primary Registration District No. 6112B

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Illmo, Mo
(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 31 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Illmo Mo
(If outside city or town limits, write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frances Jane Bishop
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mch. 11 day _____
year 1944 hour 9-55 minute A M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Sam Bishop 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 3, 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 31 1943 19 to Mch. 11 1944 19 _____
that I last saw her alive on Mch. 11 1944 19 _____
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>5</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Chronic myocarditis Duration 2 yrs

9. Birthplace West Plains Mo
(City, town, or county) (State or foreign country)
10. Usual occupation House Keeper

Due to Senility
Due to _____

11. Industry or business _____
12. Name Taylor
13. Birthplace Don't know
(City, town, or county) (State or foreign country)
14. Maiden name Emilie Katherine Edwards
15. Birthplace N.C.
(City, town or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 92d

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER, FATHER {
16. (a) Informant Mrs Irene Corder
(b) Address Illmo
17. (a) Buriah (b) Date thereof 3-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lightner Cem Illmo Mo
18. (a) Signature of funeral director Bispinghoff & Hubbard
(b) Address Illmo Mo
19. (a) 3-11-44 (b) G. S. Williams
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury ✓
23. Signature G. S. Williams (M. D. or other) M. D.
Address Illmo, Mo. Date signed 3-11-44

RECEIVED

District Health Office No. 2,

District File Number 44-474

Date Filed 4-4-44

APR 24 1944

APR 19 1944

APR 18 1944

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 Mamie Bevinghoff

Licensed Embalmer No. 3242

P. O. Address Chaffee M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.