

FILED MAY 10 1944  
Registration District No. 275

State File No. \_\_\_\_\_

Primary Registration District No. 3053

Registrar's No. 52

1. PLACE OF DEATH:

(a) County Phelps  
(b) City or town Kolla  
(c) Name of hospital or institution Nelle McFarland Memorial Hospital  
(d) Length of stay: In hospital or institution 16 hrs.  
In this community 16 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds  
(c) City or town Bunker  
(d) Street No. X  
(e) Citizen of foreign country? X  
If yes, name country X

3. (a) PRINT FULL NAME Grace Quick

3. (b) If veteran, name war X  
3. (c) Social Security No. X

4. Sex Female 5. Color or race W.  
6. (a) Single, widowed, married, divorced 1  
6. (b) Name of husband or wife Edward Quick 6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased May 30 1903

8. AGE: Years 40 Months 10 Days 26  
If less than one day hr. min.

9. Birthplace Bunker Mo.

10. Usual occupation housewife

11. Industry or business X

MOTHER FATHER { 12. Name Abe Gordon  
13. Birthplace Bunker Mo.  
14. Maiden name Etta Williams  
15. Birthplace X

16. (a) Informant Ed Quick

(b) Address Bunker Mo.

17. (a) burial (b) Date thereof 4/28/44

(c) Place: burial or cremation Bunker Mo.

18. (a) Signature of funeral director Carl K. Jansen

(b) Address Salem Mo.

19. (a) 4/26. 1944. (b) J. Collins Weaver

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26<sup>th</sup>  
year 1944 hour 12 minute 50 P.M.

21. I hereby certify that I attended the deceased from April 25, 1944 to April 26, 1944  
that I last saw her alive on April 26, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of Gall bladder

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

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

Other conditions (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? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature J. Collins Weaver (M.D. or other) \_\_\_\_\_

Address Kolla Mo. Date signed 4/26/44

**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..... *Carl H. Jensen*

Licensed Embalmer No. *370*

P. O. Address..... *Dallas, W.*

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

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

Registration District No. 275

Primary Registration District No. 3053

1. PLACE OF DEATH:

(a) County Phelan  
(b) City or town Rolla  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Grace Jusch

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 3 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased May 30 1900  
(Month) (Day) (Year)

8. AGE: Years 40 Months 10 Days 10 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 26 Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Inflamatory condition. Duration \_\_\_\_\_

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

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

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Cherry Page (M, D, or other) \_\_\_\_\_  
Address Rolla Mo Date signed 5/27/44

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

SUPPLEMENTAL

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