

FILED JAN 15 1945

Registration District No. 278

Primary Registration District No. 3054

Registrar's No.

1. PLACE OF DEATH:

(a) County Louisiana  
(b) City or town Louisiana Mo 2  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
In this community 2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike 22  
(c) City or town Louisiana Mo 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 107 Frankford Road 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

3. (a) PRINT FULL NAME MARTHA Elizabeth ELZEA

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife William Elzea (c) Age of husband or wife if alive 18 years  
7. Birth date of deceased 3-31-1867 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 1 (If less than one day min.)

9. Birthplace Ralls Co Mo U (City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business Home

12. Name L. B. Hicklin

13. Birthplace Ralls Co Mo U (City, town, or county) (State or foreign country)

14. Maiden name Emmily Crossman

15. Birthplace Ralls Co Mo U (City, town, or county) (State or foreign country)

16. (a) Informant Mr. W. Shurford

(b) Address Louisiana Mo

17. (a) Burial (b) Date thereof 12-4-44 (Month) (Day) (Year)

(c) Place: burial or cremation New London Mo

18. (a) Signature of funeral director W. H. Haley

(b) Address Louisiana Mo

19. (a) 12/4/44 (Date received local registrar) (b) W. H. Haley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2 year 1944 hour 2 minute 15 P M.

21. I hereby certify that I attended the deceased from 12-2-44 to 12-2-44 that I last saw her alive on 12-2-44 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration

Due to arteriosclerosis

Due to arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: none Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence none

(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 None

23. Signature W. H. Haley (M.D. or other)

Address Louisiana Mo Date signed 12/4/44

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

*Dr. A. A. ...  
Baptist*

RECEIVED  
District Health Officer No. 10  
District File Number *1-45-130*  
Date Filed *JAN 12 1945*

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. Wagner*, Registered Apprentice No.....  
working under my personal supervision.

Signed *George O. Wagner*

Licensed Embalmer No. *3173*

P. O. Address *Louisiana, 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.