

FILED FEB 5, 1945  
Registration District No. 171

Primary Registration District No. 4267

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Odessa  
(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 50 Yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette  
(c) City or town Odessa  
(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 Jan. day 6  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec. 10  
1944 to Jan 6, 1945  
that I last saw her alive on Jan 6, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Emphysema  
Duration \_\_\_\_\_

Due to 11a  
Due to \_\_\_\_\_

Other conditions Arteriosclerosis, Fibrosclerosis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no 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) M  
(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?

(Specify type of place)  
While at work \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature M. D. Morton (M. D. or other)  
Address Odessa Mo. Date signed 1-20-45

3. (a) PRINT FULL NAME Bridget McGirl  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased Jan. 20 1874  
(Month) (Day) (Year)

8. AGE: Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Patrick Bowlen  
13. Birthplace 4 Ireland (City, town, or county) (State or foreign country)  
14. Maiden name Breen  
15. Birthplace 4 Ireland (City, town, or county) (State or foreign country)

16. (a) Informant James McGirl  
(b) Address Thlsa, Okla.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1945  
(Month) (Day) (Year)  
(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director F. C. Husman  
(b) Address Odessa, Mo.

19. (a) Jan. 26-1945 (b) Mrs W. B. Baker  
(Data received local registrar) (Registrar's signature)

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

54  
4  
0

1157

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

2-2-45

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 *George T. Hoover*

Licensed Embalmer No. 2541

P. O. Address: Odessa, 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.