

Registration District No. 333

Primary Registration District No. 3-0-7-4-6115

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH: Scott

(a) County Scott

(b) City or town Sikeston R 2  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Deer Creek  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town Sikeston  
(If outside city or town limits, write "RURAL") 100

(d) Street No. R 2 (If rural, give location) A

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) A

If yes, name country \_\_\_\_\_ O

3. (a) PRINT FULL NAME DOROTHY NADINE CHROZIER

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased: Aug 18 1925  
(Month) (Day) (Year)

8. AGE: Years 19 Months 4 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Morehouse Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

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

12. Name Elmer Chrozier

13. Birthplace Morehouse Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Lavera Baker

15. Birthplace Salcido Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant John Martin

(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof 1-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Sikeston Mo

18. (a) Signature of funeral director Welch Funeral Home

(b) Address Sikeston Mo

19. (a) 2/5/45 (b) Louis Lergub  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8  
year 1945 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from Jan 8 1945 to Jan 8 1945  
that I last saw her alive on Jan 8 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_ 13 h

Other conditions Pneumonia, Flu  
(Include pregnancy within 3 months of death) 27th Street

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) \_\_\_\_\_  
Means of injury 0

23. Signature D. K. Jensen (M. D. or other) \_\_\_\_\_

Address Sikeston, Mo. Date signed 1-11-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 245-245

Date Filed 2-15-45

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.