

FILED MAR 14 1945

Registration District No. 328

Primary Registration District No. 3073

Registrar's No. 4

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

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: 411 Wright
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott

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

(d) Street No. 411 Wright Ave. 1
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME BERTHA ETHEL SPEER

(b) If veteran, ✓ name war _____

(c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7th year 1945 hour 7 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 1944 to Feb. 7 1945; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (c) Age of husband or wife if alive ✓ years 2

7. Birth date of deceased: Nov 2 1876
(Month) (Day) (Year)

Immediate cause of death: Dropsy, glomerulo-chronic nephritis

Duration 20 yrs.

8. AGE: Years 68 Months 2 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Lynnsville, Indiana
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Housework

11. Industry or business _____

12. Name Scott Brooks

13. Birthplace no record, Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Mabel Byers

15. Birthplace no record
(City, town or county) (State or foreign country)

Major findings: 131 1/2

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. E. L. Banell

(b) Address Chaffee Ten

17. (a) Burial (b) Date thereof 2-11-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brynmead Cem.

18. (a) Signature of funeral director M. M. DeLeon

(b) Address Chaffee Mo.

19. (a) 2-20-1945 (b) Christa Erave
(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)

(e) Means of injury _____

23. Signature Mabel M. DeLeon M. D. or other 20

Address Chaffee - 2076 Date signed 2-10-45

1325

RECEIVED

District Health Office No. 2

District File Number

345-41

Date Filed

3/8/4

AUG 30 1954

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.....

C. J. Lohberg

Licensed Embalmer No.

3810

P.O. Address.....

Cape Girardeau, 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.