

X29484

REC'D JUN 9 1945
Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 173

1. PLACE OF DEATH

(a) County Callaway
(b) City or town Millton
(c) Name of hospital or institution State Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-4-30
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Ralls
(c) City or town Laddonia
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

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

4. Sex Female 5. Color or race W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 21-1908
(Month) (Day) (Year)

8. AGE: Years 36 Months 9 Days 23
If less than one day _____ hr. _____ min.

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

10. Usual occupation Wk

11. Industry or business _____
12. Name Chas. A. Stevens
13. Birthplace Ill (City, town, or county) (State or foreign country)
14. Maiden name Ball Baker
15. Birthplace Va (City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital
(b) Address Millton mo

17. (a) Removal (b) Date thereof May 24 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laddonia mo

18. (a) Signature of funeral director Earl E. Precht
(b) Address Merico mo

19. (a) May 24-1945 (b) John Moravickoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1945 hour 5 minute 0 A. M.

21. I hereby certify that I attended the deceased from 11-20-1945 to 5-24-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 17W

Of autopsy same

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? _____ (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 R.E. Stevens (M. D. or other) _____
Address Millton mo Date signed 5/24/45

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

4
1
2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 6-7-45

JUL 23 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Earl E. Brecht

Licensed Embalmer No. 2189

P. O. Address Maine Me

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.