

FILED JUN 2 1945
Registration District No. 3

Primary Registration District No. 6129

Registrar's No. _____

1. PLACE OF DEATH: SHANNON

(a) County: SHANNON

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

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED: 101

(a) State: MISSOURI (b) County: SHANNON

(c) City or town: SUMMERSVILLE
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: ALMA WILCOX

3. (b) If veteran, name war: None

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: MAY day: 24
year: 1945 hour: 7 minute: A.M.

21. I hereby certify that I attended the deceased from MAY 24 1945 to MAY 24 1945
that I last saw him alive on MAY 24 1945
and that death occurred on the date and hour stated above.

4. Sex: FEMALE

5. Color or race: WH

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

6. (b) Name of husband or wife: LESSLIE WILCOX

6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: March 16 1916
(Month) (Day) (Year)

Immediate cause of death: Acute Myocarditis

Due to: Disturbance of Pituitary Gland

Due to: _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: A3a

Of autopsy: _____

8. AGE: Years: 29 Months: 2 Days: 8
If less than one day: _____ hr. _____ min.

9. Birthplace: SUMMERSVILLE MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation: HOUSEWIFE

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business: _____

12. Name: BARKETT CARTER

13. Birthplace: UNKNOWN 9
(City, town, or county) (State or foreign country)

14. Maiden name: MARTHA VAN HORN

15. Birthplace: UNKNOWN 0
(City, town, or county) (State or foreign country)

16. (a) Informant: LESSLIE WILCOX (HUSBAND)

(b) Address: SUMMERSVILLE

17. (a) BURIAL (b) Date thereof: May 25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Hebron Cemetery

18. (a) Signature of funeral director: _____

(b) Address: _____

19. (a) 3-29-45 (b) Frank Hyde MD
(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: _____ (M. D. or other) _____
Address: _____ Date signed: _____

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

RECEIVED

District Health Officer No. 5,

District File Number

545-272

Date Filed

21.9.45

JUN 28 1945

RECORDED

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.....



[Handwritten signature]

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.