

FILED AUG 9 1945

Registration District No. **187**

Primary Registration District No. **5675**

Registrar's No. **24**

1. PLACE OF DEATH: **Lincoln**

(a) County **Lincoln**

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

(c) Name of hospital or institution: **2011**
(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 **Lincoln**

(c) City or town **Elstun Rural**
(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 _____

3. (a) PRINT FULL NAME **Mamie Lorine Graves**

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7**
year **1945** hour **6** minute **30 P.M.**

4. Sex **F** 1 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: **April** **20** **1916**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

8. AGE: Years **35** Months **2** Days **12** If less than one day _____ hr. _____ min.

Immediate cause of death: **Broken neck and chest concussion directly over the cardiac region (coroner's jury verdict)**

Due to _____

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

9. Birthplace **Tyler Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House work**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **Henry Coats**

13. Birthplace **Jacksonville Miss.**
(City, town, or county) (State or foreign country)

14. Maiden name **Ethel Coats**

15. Birthplace **Hotchkiss Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ethel Ward**

(b) Address **2 Louisiana MO. R. 2**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **July 2 1945**

17. (a) **Burial** (b) Date thereof **July 4 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bowling Green**

(c) Where did injury occur **Highway 99 Lincoln Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Public**

18. (c) Signature of funeral director **W. W. Bradley**

(b) Address **Elstun**

19. (a) **July 9 1945** (b) **S. L. Williams**
(Date received local registrar) (Registrar's signature)

While at work? **yes** (Specify type of place) _____

(e) Means of injury _____

23. Signature **V. E. Althoff** (M. D. or other) _____
Address **Coroner Lincoln Co. Mo.** Date signed **7/12/45**

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

7
0
0

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 8-8-45

JUL 20 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 W. H. Bradley
Licensed Embalmer No. 3966
P. O. Address Elberry

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Rural
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Mamie L. Groves

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

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

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

7. Birth date of deceased April 20, 1910
(Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) _____ min.
35 2 2

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

10. Usual occupation Housework

11. Industry or business ---

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

State Highway Patrol:

Due to Non-Collision, Ran off Roadway

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of 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) _____

(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

MOTHER FATHER

SUPPLEMENTARY

11028
28

S-24393