

FILED DEC 8 1945 STANDARD CERTIFICATE OF DEATH

State File No. **36842**

Registration District No. **53**

Primary Registration District No. **3010**

Registrar's No. **393**

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

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (c) Name of hospital or institution: South East Mo. Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 In this community 1 day
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Cape Girardeau
 (c) City or town Jackson
 (d) Street No. 816 Cape Road
 (e) Citizen of foreign country? NO
 If yes, name country.

3. (a) PRINT FULL NAME Frances Jane Statler

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased October 14 1939
 (Month) (Day) (Year)

8. AGE: Years 6 Months 1 Days 15 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Woodrow Statler

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

14. Maiden name Hazel Bollinger

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

16. (a) Informant Woodrow Statler
 (b) Address Jackson Mo.

17. (a) Burial (b) Date thereof 12 1 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedgewickville Mo.

18. (a) Signature of funeral director Wilson Statler Seabough
 (b) Address 12-4-1945
 19. (a) 12-4-1945 (b) C. V. Summer
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1945 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 28, 1945, to Nov 29, 1945—
 that I last saw her alive on Nov 29, 1945—
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 5 day

Due to _____

Due to _____

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

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)
 (e) Means of injury 0
 23. Signature T. E. Ruff (M. D. or other) M.D.
 Address Jackson Mo. Date signed 12/3/45

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4

District File Number 1245-140

Date Filed 12-6-45

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

Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address *Jackson 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.