

FILED DEC 5 6 1945

Registration District No. ....

Primary Registration District No. 3127

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
IIO South Penn. Res. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 55 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49  
(c) City or town Webb City  
(If outside city or town limits, write "RURAL")  
(d) Street No. IIO So. Penn.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Lulu Elizabeth Gray.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 9

No Data

8. AGE: Years No Data

Months Sept. 9

Days If less than one day hr. min.

9. Birthplace Dennison Texas

(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business \_\_\_\_\_

12. Name William Shelton

13. Birthplace Dennison Texas

(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth No Data

15. Birthplace \_\_\_\_\_ Texas

(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nadine Grey Dosbaugh

(b) Address IIO So. Penn. Webb City, Mo

17. (a) Burial (b) Date thereof II/6-45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cem.

18. (a) Signature of funeral director Hedge-Lewis

(b) Address Webb City Mo.

19. (a) 11-5-45 (b) \_\_\_\_\_

(Date received local registrar) (Registrar's signature)

1040

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4  
year 1945 hour 3 minute 35 P.M.

21. I hereby certify that I attended the deceased from 11-4 1945 to 11-4 1945  
that I last saw him alive on 11-4 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings: Of operations: [Signature]

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 \_\_\_\_\_  
Signature: [Signature] (M. D. or other) \_\_\_\_\_  
Address: [Signature] Date signed 11-2-45

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

19  
6  
2

**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. Hedge*  
2859  
*Webb, P. O.*

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.**