

No. 2
-8-43
-17-39
X37823

FILED JUN 13 1946
Registration District No. **187**

Primary Registration District No. **5701**

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

1. PLACE OF DEATH:

(a) County **Lumpkin**

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

(c) Name of hospital or institution: **1**

(If not in hospital or institution, write street number or location)

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

In this community **45 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Lumpkin 59**

(c) City or town **Rural**
(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 **Laura Bell Singleton**

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

4. Sex **F** 5. Color or race **W** 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 **Apr 16 1859**
(Month) (Day) (Year)

8. AGE: Years **87** Months **1** Days **10** If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Crawford**

13. Birthplace **Don't know**
(City, town, or county) (State or foreign country)

14. Maiden name **Phyllis Snow**

15. Birthplace **Don't know**
(City, town, or county) (State or foreign country)

16. (a) Informant **James Singleton**

(b) Address **Utica Mo.**

17. (a) **Burial** (b) Date thereof **5-29-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Utica Cem.**

18. (a) Signature of funeral director **E. Beckert 43227**

(b) Address **Chellicath Mo.**

19. (a) **5-27-46** (b) **Thathleen Potts**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **26**
year **1946** hour _____ minute **25-4** M.

21. I hereby certify that I attended the deceased from **May 21 1946** to **May 25 1946**
that I last saw her alive on **May 25 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Convulsion & Shock** Duration **1 week**

Due to _____

Due to _____

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

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED** PHYSICIAN _____
Of operations _____
Of autopsy _____ 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) **May 19-1946**

(b) Date of occurrence **before 1946**

(c) Where did injury occur? **Utica Lumpkin Mo**
(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. Court. R. 2** (M. D. or other) _____

Address **Chellicath Mo** Date signed **5-27-46**

Richard B. Smith

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

was embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Richard B. Smith*.....

Licensed Embalmer No. *3227*

P. O. Address *Chillicothe Mo*

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 CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JumpRegistration District No. 189Primary Registration District No. 5701Registrar's No. 7

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Libica
(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 _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Laura B. Singleton

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

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

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

7. Birth date of deceased April 16 (Month) (Day) (Year)8. AGE: Years 67 Months _____ Days _____ (Unless less than one day) hr. _____ min.

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

10. Usual occupation _____

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

(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 1946 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. Duration
Immediate cause of death _____Due to Was run into by a truck4 days previous to deathDue to Fallen back on head

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

Major findings: _____ Of operations _____

Of autopsy 186-19

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

16182

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

17301