

FILED OCT 11 1946
Registration District No. 239

Primary Registration District No. 5825

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Catron
(c) Name of hospital or institution:
None
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Grace Vivian Outlaw
3. (b) If veteran, name war ✓
3. (c) Social Security No. None

4. Sex F
5. Color of hair White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Neal J. Outlaw
6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased April 8 1924
(Month) (Day) (Year)

8. AGE: Years 22 Months 5 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name George W. Wagon
13. Birthplace State of Miss
(City, town, or county) (State or foreign country)

{ 14. Maiden name Marie Elaine
15. Birthplace State of Miss
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Neal J. Outlaw
(b) Address Catron Mo

17. (a) Burial (b) Date thereof Sept 10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dontine Miss

18. (a) Signature of funeral director W. W. ...
(b) Address Parma Mo

19. (a) 9/19/46 (b) Dr. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Catron
(If outside city or town limits, write "RURAL")
(d) Street No. ✓ (If rural, give location)
(e) If foreign born, how long in U. S. A.? None years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 8
year 1946 hour 1 minute 40 A. M.
21. I hereby certify that I attended the deceased from 8-22-46, 19____, to 9-8-46, 19____;
that I last saw him alive on 9-7-46, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Wolfe's disease
Due to _____

Due to _____

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

Major findings: Of operations 44B
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)
(c) Means of injury _____

23. Signature W. W. ... (M. D. or other) MD
Address Parma Mo Date signed 9/19/46

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

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REV. 3-1-41

RECEIVED

District Health Office No. 2

District File Number 1046-1205

Date Filed 10-7-46

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.....

Licensed Embalmer No. 2476

P. O. Address Wester Ms

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, above space should be left blank.