

V. S. No. 2
 00M-5-43
 Rev. 5-17-39
 1 X36671

FILED MAR 31 1947

Registration District No. _____

Primary Registration District No. 3033

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Laclede
 (b) City or town Lebanon
 (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 entire life (Specify whether)
 years, months or days

3. (a) PRINT FULL NAME Nellie Josephine Meachum
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Celoid
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Frank Meachum 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 17 1890
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 8 27 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name John Chateau 9

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

14. Maiden name Sarah Christensen

15. Birthplace Pulaski Co. Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Juanita Williams
 (b) Address Lebanon Mo.

17. (a) Burial (b) Date thereof 3-14-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. G. Holman

(b) Address Lebanon Mo.

19. (a) 3-22-47 (b) Dr. Frank Burger
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Laclede 53
 (c) City or town Lebanon 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. St Louis Ave no house number 2
 (If rural, give location)
 (e) Citizen of foreign country? NO 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
 year 1947 hour 9 minute 55 P.M.
 21. I hereby certify that I attended the deceased from Dec. 31
 1946, to Mar. 8 1947;
 that I last saw her alive on Mar. 8 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death acute cardiac failure Duration 2 days
 Due to Chronic cardiac decompensation 7 mo.
 Due to Nephritis, chronic ?

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 Sec Carrington (M. D. or other) M.D.
 Address Lebanon Mo. Date signed 3/13/47

Received 3/27/47
Laclede County Health Unit
File No. 3/47/43
Date Filed 3/27/47

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 Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon, 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.