

FILED MAY 28 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 188

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

1. PLACE OF DEATH:

(a) County Galloway

(b) City or town Fulton

(c) Name of hospital or institution State Hospital No. 1

(d) Length of stay: In hospital or institution 11 years 8 M

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin

(c) City or town Flowerville

(d) Street No. 1

(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME EDNA P. PILCHER.

3. (b) If veteran, name war. _____

3. (c) Social Security No. _____

4. Sex F. Color or race W.

5. Color or race W.

6. (a) Single, widowed, married, divorced S. D.

6. (b) Name of husband or wife _____

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

7. Birth date of deceased D.K.

8. AGE:

Years	Months	Days	If less than one day
<u>29</u>			hr. _____ min.

9. Birthplace D.K.

10. Usual occupation none

11. Industry or business none

MOTHER FATHER

12. Name D.K.

13. Birthplace D.K.

14. Maiden name D.K.

15. Birthplace D.K.

16. (a) Informant Hospital Records

(b) Address Fulton Mo.

17. (a) Removal (b) Date thereof 5-21-47

(c) Place: burial or cremation Columbia mo

18. (a) Signature of funeral director G. P. Roberts

(b) Address Columbia mo

19. (a) 5-21-1947 (b) Jose M. M... [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 20

year 1947 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from 5-15-47, 1947, to 5-20-47, 1947;

that I last saw h ER alive on 5-19-47, 1947;

and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

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? _____

(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 R. P. Price M. D. (M. D. or other) _____

Address Fulton Mo. Date signed 5-20-47

RECEIVED
District Health Officer No. 93
District File Number
Date Filed 5-27-47

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.....

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.