

1-5-43
-17-39
X36671

FILED MAY 22 1947

State File No. _____

Registration District No. 3253

Primary Registration District No. 3010

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Cape Girardeau

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

(c) Name of hospital or institution:
St. Francis Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 wk.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Union

(c) City or town Anna
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lona M. Ginnis

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 Single

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

7. Birth date of deceased: Dec. 25 1975
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7 AM
year 47 hour 1:30 minute AM

21. I hereby certify that I attended the deceased from 3-1, 1947 to 5-7, 1947
that I last saw her alive on 5-6-47, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal obstruction

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>4</u>	<u>12</u>	hr. _____ min. _____

Due to Carcinoma of Desc. Colon

Due to _____

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

Major findings: Carcinoma Desc. Colon
Of operations: not made

Of autopsy: not made

9. Birthplace Union Co Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Practical Nurse

11. Industry or business ✓

MOTHER FATHER { 12. Name George M. Ginnis

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

14. Maiden name Anna

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

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? _____

16. (a) Informant Mrs. Tom Bushard

(b) Address Chaffee Mo

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 5-8-47
(Month) (Day) (Year)

(c) Place: burial or cremation Union Park Chaffee Mo

18. (a) Signature of funeral director Bisplinghoff Funeral Home

(b) Address Chaffee Mo

19. (a) 5-9-47
(Date received local registrar)

(b) E. S. Summers
(Registrar's signature)

23. Signature W. D. Dunge (M. D. or other) 4/7/47

Address Chaffee Mo Date signed 4/7/47

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

RECEIVED

District Health Officer No. 4
District File Number 547-734
Date Filed 5-21-47

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.....

Jack T. Burnett

....., Registered Apprentice No. 516

working under my personal supervision.

Signed *Mamie Bispling Hoff*

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.

Registration District No. 53

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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 _____
years, months or days

3. (a) PRINT FULL NAME Lena Mc Ginnis

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 S

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

7. Birth date of deceased Dec 25 (Month) (Day) (Year)

8. AGE: Years 71 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) 6-9-1947 (b) C. C. Summers (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 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

16772