

FILED MAY 24 1948

Registration District No. **228**

Primary Registration District No. **4472**

Registrar's No. **15**

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Oran
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Oran
(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 Amelia Jane Rollins

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1948 hour 4 minute 15 AM.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife S. P. Rollins 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased September 17 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 11th, 1948 to May 12th, 1948 that I last saw her alive on May 12th, 1948 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>7</u>	<u>11</u>	hr. _____ min.

Immediate cause of death congestive Cardiac Failure Duration 2 wks.

9. Birthplace Hickman County Kentucky
(City, town, or county) (State or foreign country)

Due to gadio-vascular disease

Due to _____

10. Usual occupation Housewife

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

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

Major findings: Of operations _____
Of autopsy _____

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

16. (a) Informant Mrs. Daisy Graviett
(b) Address Vanduser, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-48
(Month) (Day) (Year)

(c) Place: burial or cremation Friend Cemetery

(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) (Means of injury)

18. (a) Signature of funeral director Carl J. Smith
(b) Address Oran, Mo.

19. (a) 5/18/48 (b) GP MacCreeg
(Date received local registrar) (Registrar's signature)

23. Signature Dr. J. S. Burt (M. D. or other) D.O.
Address Oran, Mo. Date signed 5/17/48

RECEIVED

District Health Office No. 2

District File Number 548-669

Date Filed 5-21-48

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 Earl J. Smith

Licensed Embalmer No. 3676

P. O. Address Orem, 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.