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DC47070

FILED OCT 19 1948

Registration District No. **20**

Primary Registration District No. **5095**

Registrar's No. **53**

**1. PLACE OF DEATH:**

(a) County **Bates**

(b) City or town **Rural Mingo**

(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 **40 years**  
years, months or days

**3. (a) PRINT FULL NAME** **Lula Ewing**

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 **Widowed**

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased **February 5 1876**  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<b>72</b>	<b>0</b>	<b>4</b>	hr. _____ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business **Homemaker**

12. Name **Wm Simpson**

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

14. Maiden name **Mamella Dunbar**

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

16. (a) Informant **Glen Ewing**

(b) Address **Wich MO**

17. (a) **Burial** (b) Date thereof **10-11-1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **White Oak**

18. (a) Signature of funeral director **Robert Small**

(b) Address **Craighton Mo**

19. (a) **10-12-48** (b) **Myra Owens**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Bates**

(c) City or town **Rural Mingo**  
(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 **10** day **9**  
year **1948** hour **11** minute **45 AM**

21. I hereby certify that I attended the deceased from **9/30**, 19**48** to **10/5**, 19**48**  
that I last saw her alive on **10/5**, 19**48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**

Duration

**10/2/48**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations **None**

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 job)

23. Signature **R. G. Powell** (M. D. or other) **MD**

Address **Chick Tom Sw** Date signed **10/10/48**

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

RECEIVED

District Health Officer No. 71

District File Number 9-48-1218

Date Filed 10-18-48

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 Robert Arnold

Licensed Embalmer No. 3621

P. O. Address Crofton Md

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.