

FILED MAR 28 1944  
 Registration District No. 316

Primary Registration District No. 4462

1. PLACE OF DEATH

(a) County St. Francois  
 (b) City or town Clinton, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community no. years, months or days)

3. (a) PRINT FULL NAME

Laura Mahurjan

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

4. Sex A 5. Color or race W 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife John Mahurjan 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 66 Months \_\_\_\_\_ Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Dent Co. MO. (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Barney Lupton

13. Birthplace Dent Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant Mrs. James Merritt

(b) Address Clinton, Mo.

17. (a) Burial (b) Date thereof 2 2 1944 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bertrand Mo.

18. (a) Signature of funeral director Caldwell Bros.

(b) Address Flat River Mo.

19. (a) March 3-1944 (b) B. B. Buhmester (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
 (c) City or town Clinton, Mo. (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29 year 1944 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 10 1942 to \_\_\_\_\_ 1944  
 that I last saw her alive on 2-29 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death trauma-fracture Duration 3 days

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

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

Other conditions (In this pregnancy, within 3 months of death) Parturient Palsy

Major findings: before Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) D.S. 3

(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? no (Specify type of place) (e) Means of injury ✓

23. Signature J. P. Stabile (M. D. or other)

Address DeSoye Mo. Date signed 3-3-44

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

4  
3  
0

1196

RECEIVED

District Health Officer No. 4  
District File Number 344-360  
Date Filed 3-27-44

**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.**

Registration District No. 316

Primary Registration District No. 4462

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St Francis  
(b) City or town Quinn  
(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 Laura Mahurnan

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 in

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

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

8. AGE: Years 66 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

11. Industry or business \_\_\_\_\_

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) (Date received local registrar) (b) (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 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia

Due to 1944

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

Other conditions Parkinson's Disease  
(Include pregnancy within 3 months of death)

Major findings: ADDITIONAL Dr. R. Shipman

Of operations: SUPPLEMENTARY fall 2 weeks

Of autopsy: INFORMATION before

Underline the cause to which death should be charged statistically. REQUESTED

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

(a) Accident, suicide, or homicide (specify) or fall in fall

(b) Date of occurrence July 4-1944

(c) Where did injury occur? the kitchen table next to

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home on farm

While at work? \_\_\_\_\_ (Specify type of place) accident

23. Signature H. C. Baker (M. D. or other) \_\_\_\_\_

Address Dealega Date signed 7-19-44

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

SUPPLEMENTARY

11954