

FILED APR 10 1947

Registration District No.

Primary Registration District No. 3042

State File No.

Registrar's No. 187

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Fredricktown, St. Michael
(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

Alice De Laure

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex 2 1

5. Color or
race W

6. (a) Single, widowed, married,
divorced widow

6. (b) Name of husband or wife

John De Laure

6. (c) Age of husband or wife if
alive Dec 30 1867

7. Birth date of deceased

Nov

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

79

4

22

hr.

min.

9. Birthplace

Madison

(City, town, or county)

(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Whiter Lunsford

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

Mary Ann Gross

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

Mrs. Pearl Powell

(b) Address

St. Louis, Mo

17. (a)

Burial

(b) Date thereof

3

(Month)

(Day)

(Year)

(c) Place: burial or cremation

Christiansburg

18. (a) Signature of funeral director

W. B. Barlow

(b) Address

Fredricktown, St. Michael

19. (a)

3-31-47

(b)

Florence Backe

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Mo

(b) County

Madison

(c) City or town

210 Kelly

Fredricktown

(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

Mar.

day

22

year

1947

hour

7:15

minute

PM

19

to

47

21. I hereby certify that I attended the deceased from

that I last saw him alive on

Mar 21

7:30 PM

19

to

47

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

Immediate cause of death

Heart Failure

Had Bronchitis & Flu

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Bronchial Rube

Of autopsy

none

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)

no

(b) Date of occurrence

none

(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. B. Barlow

(M. D. or other)

Address

Fredricktown

Day

Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4
District File Number 442-505
Date Filed 4-9-47

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. 4264

P. O. Address Fredericktown, 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.