

FILED MAR 14 1940

Registration District No. 827

Primary Registration District No. 4500

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Shelby

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

(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community yes
years, months or days) _____

3. (a) PRINT FULL NAME WIONA MAYLOR

3. (b) If veteran, name war. no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife W.E. Maylor (c) Age of husband or wife If alive, deceased years

7. Birth date of deceased Mar 18 - 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 11 27 hr. min.

9. Birthplace Nickelton Shelby Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

12. Name David Nickells

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

14. Maiden name Frances Snell

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

16. (a) Informant Nickell Maylor

(b) Address Cleveland Ohio

17. (a) Burial (b) Date thereof 2-22-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation maple wood

18. (a) Signature of funeral director Millon Barber

(b) Address Clarence Mo

19. (a) 2-22-40 (b) Ray Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby

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

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

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20
year 1940 hour 9:00 minute 30 a.m.

21. I hereby certify that I attended the deceased from Feb 12 1940 to Feb 20 1940
that I last saw he alive on Feb 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Duration 7 days

Due to Influenza 54 9 days

Due to _____

Other conditions diabetes mellitus 10 years
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: none

Of operations _____

Of autopsy none

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 no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (c) Means of injury no

23. Signature D. L. Harlan (M. D. or other) MD

Address Clarence Mo Date signed Feb 21/40

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

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RECEIVED
District Health Officer No. 10
District File Number 3-40-680
Date Filed MAR 13 1940

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 *Henry A. Backebee*

Licensed Embalmer No. *3835*

P. O. Address *Shelburne, 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, above space should be left blank.