

Registration District No. **218**

Primary Registration District No. **3015**

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Boonville  
(c) Name of hospital or institution: St. Joseph Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Weeks.  
In this community All of life.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper  
(c) City or town Boonville, Rural.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th.  
year 1940 hour 2:45 minute P. M.  
21. I hereby certify that I attended the deceased from 1938  
\_\_\_\_\_, 19\_\_\_\_ to June 14, 1940  
that I last saw her alive on June 14, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death aplastic anemia  
Duration \_\_\_\_\_

Due to unknown

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

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

Major findings: none  
Of operations \_\_\_\_\_  
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) \_\_\_\_\_  
(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 place)  
(a) Means of injury \_\_\_\_\_

23. Signature T.C. Beckett (M. D. \_\_\_\_\_)  
Address Boonville, mo Date signed 6-15-40

3. (a) PRINT FULL NAME Mrs. Mary R. Atkinson. **325**

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

7. Birth date of deceased August 17th. 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 9 28 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Cooper County Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business At home.

12. Name Ewing Roberts.

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

14. Maiden name Sarah M. Rockwood  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Chas. S. Atkinson, Jr.  
(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof June 17<sup>th</sup>/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Walnut Grove Cem.

18. (a) Signature of funeral director Goodman & Sollen  
(b) Address Boonville, Mo.

19. (a) 6-17-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 7-3-40

**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 J. M. Goodman  
Licensed Embalmer No. 1178  
P. O. Address Besseville, 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.