

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6262  
Registrar's No. 9

ED MAR 19 1941  
Registration District No. 2

Primary Registration District No. 4049

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town DeKalb  
(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 1 yr years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town DeKalb  
(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

3. (a) PRINT FULL NAME MARY MARILLA RESNOY  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none  
4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 26 1960  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 2 day 27  
year 1941 hour 6 minute 25 P.M.  
21. I hereby certify that I attended the deceased from Jan 3, 1941  
\_\_\_\_\_, 19\_\_\_\_, to Feb. 27, 1941;  
that I last saw her alive on Feb 27, 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
80 7 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Advanced myocarditis Duration 10 days  
Senility  
Due to Chronic myocarditis 10 yrs.  
Chronic nephritis

9. Birthplace paola 1 Iowa  
(City, town, or county) (State or foreign country)  
10. Usual occupation at home

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

11. Industry or business \_\_\_\_\_  
12. Name James A. Gloy  
13. Birthplace unknown Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Clara Allen  
15. Birthplace Bertry Omo  
(City, town, or county) (State or foreign country)

Major findings: 12/16  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs. Clara Clark  
(b) Address DeKalb mo.  
17. (a) B (b) Date thereof 2-2-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation pickering mo  
18. (a) Signature of funeral director E. C. Breit  
(b) Address Savannah mo  
19. (a) Mar. 4/41 (b) Ch. Davis  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury \_\_\_\_\_  
23. Signature Benjamin M. Tates (M. D. or other) No. 12  
Address DeKalb, mo Date signed 2/27/41

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 E. C. Diet

Licensed Embalmer No. 2650

P. O. Address Savannah 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.**