

No. 2
-2-43
-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31631

State File No. _____

FILED OCT 9 1943

Registration District No. 122

Primary Registration District No. 4201

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic
(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 _____ (Specify whether
years, months or days) 6 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 039

(c) City or town Republic
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Mary Viola Earnhart

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 married

6. (b) Name of husband or wife James R. Earnhart 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased March 6th 1873
(Month) (Day) (Year)

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

70 6 24 hr. min.

9. Birthplace Christian Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Riley

13. Birthplace Ky. 1
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Goodin

15. Birthplace Ill. 1
(City, town, or county) (State or foreign country)

16. (a) Informant J. R. Earnhart

(b) Address Republic - Mo.

17. (a) Burial (b) Date thereof Oct. 2-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ponce De Leon Cem.

18. (a) Signature of funeral director J. W. Maples

(b) Address Clever - Mo.

19. (a) 10-2-1943 (b) Gloucester Britain
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1943 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 26, 1943, to Sept 20, 1943
that I last saw her alive on July 10, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis with Arteriosclerosis & Hypertension

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration _____

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) (e) Means of injury _____

23. Signature J. T. Wade (M. D. or other) _____
Address Rep. Mo. Date signed 10-2-43

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

MOTHER FATHER

RECEIVED

Greene County Health Office

County File Number 43-10-~~9~~ 104

Date Filed 10/6/43

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.W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, 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.

Registration District No. *122*

Primary Registration District No. *4201*

Registrar's No. _____

1. PLACE OF DEATH

(a) County *Sheepshead*
(b) City or town *Republic*
(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) (Specify whether

3. (a) PRINT FULL NAME *Mary Viola Earnhart*

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 *m*

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

7. Birth date of deceased *Mar 16 1916*
(Month) (Day) (Year)

8. AGE: Years *70* Months *6* 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 _____

MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 *1943* hour _____ minute _____ M.

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

Immediate cause of death *Paralysis arteriosclerous
hypertension*

Due to *Cerebral Hemorrhage*

Due to _____
Other conditions (Include pregnancy within 3 months of death) *83a*

Major findings:
Of operations _____
Of autopsy _____

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) (c) Means of injury _____

23. Signature *Garold H. Wade* (M. D. or other) _____
Address *77* Date signed *8-3-43*

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

SUPPLEMENTARY

31631