

FILED SEP 28 1943

State File No.

Registration District No. 742

Primary Registration District No. 4231

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Mountain View, Mo
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
(Specify whether years, months or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town Mountain View, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Celia May Becker

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife F.A. Becker 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased July 16th 1879
(Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name A.F. Page
13. Birthplace Ind
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Foster
15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant F.A. Becker
(b) Address Mountain View, Mo
17. (a) Burial (b) Date thereof Aug 16, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mountain View Mo

18. (a) Signature of funeral director John J. Amman
(b) Address Mountain View, Mo
19. (a) 8-30-43 (b) Ruth Hunt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14th
year 1943 hour 8 minute 15 p. M.

21. I hereby certify that I attended the deceased from 8 - 12 - 1943 to 8 - 14 - 1943
that I last saw her alive on 8 - 12 - 1943
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
ruptured Blood vessel
of brain
Due to HYPERTENSION

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 8301
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)

23. Signature P. E. Farrell (M. D. or other)

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

MOTHER FATHER

mo.

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.....
.....
.....
working under my personal supervision.

Signed..... *John J. Lunn*
Registered Apprentice No.....
Licensed Embalmer No. *27516*
P. O. Address *Mt. View 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.