

FILED FEB 14 1944

Registration District No. 49

Primary Registration District No. 4168

Registrar's No. 180

1. PLACE OF DEATH:

(a) County. DE KARB
(b) City or town. MAYSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
HOTEL DE KARB ROOM # 35
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 71 YEARS (Specify whether
In this community. years, months or days)

3. (a) PRINT FULL NAME IDA BELLE WHITE

3. (b) If veteran, name war. (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. SAMUEL S WHITE 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased. DEC 18 - 1872 (Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 27 If less than one day hr. min.

9. Birthplace DE KARB COUNTY MO (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER { 12. Name JOSEPH. b. WILLIAMS
13. Birthplace ANDREW COUNTY MO (City, town, or county) (State or foreign country)
14. Maiden name SYNTIA ANN SMITH
15. Birthplace DE KARB COUNTY MO (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charlotte Eiberger (b) Address Maysville Mo

17. (a) Burial (b) Date thereof 1-24-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Maysville

18. (a) Signature of funeral director. (b) Address Maysville Mo

19. (a) Date received by registrar 1-27-44 (b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. DE KARB
(c) City or town. MAYSVILLE (If outside city or town limits, write "RURAL")
(d) Street No. HOTEL DEKARB ROOM # 35 (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 21 year 1944 hour 6 minute 00 A.M.

21. I hereby certify that I attended the deceased from breathed the body 19 that I have seen the body 19 and that death occurred on the date and hour stated above.

Immediate cause of death. CORONARY THROMBOSIS

Due to

Due to

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

Major findings: 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) (e) Means of injury

23. Signature Arthur E. Rockwell M. D. or other Address Union Star Mo Date signed 1/24/44

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

MAR 8 1944

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 *John D. Brann*
Licensed Embalmer No. *3933*
P. O. Address *Wayville, S.C.*

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.