

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

FILED APR 20 1944
Registration District No. 2049

Primary Registration District No. 3043

1. PLACE OF DEATH: Marion

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Levering Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether)

In this community 25 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL") 7

(d) Street No. 506 Wilson St.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Katherine Ann White

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

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Maxwell R. White 6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased March 4 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business no

MOTHER FATHER { 12. Name William Jones

13. Birthplace Wales 4
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Morris

15. Birthplace Wales 4
(City, town, or county) (State or foreign country)

16. (a) Informant Maxwell R. White

(b) Address 506 Wilson St.

17. (a) Burial (b) Date thereof Apr. 4 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery, Macon

18. (a) Signature of funeral director Ray P. Schwartz MO.

(b) Address 100 Broadway

19. (a) 4/4/44 (b) W. Connor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 3
year 1944 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from Mar. 20-44
to April 3 1944
that I last saw her alive on April 3 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Ch. myocardi

Due to _____

Due to Senility

Other conditions _____

(Include pregnancy within 3 months of death) 93d

Major findings: Of operations _____

Of autopsy _____

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 0

23. Signature John Bolway (M. D. or other)

Address John Bolway Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1146

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. P. Schwartz*

Licensed Embalmer No. *1765*

P. O. Address *1000 Broadway*

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.

44/11/18