DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 31 1944

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5023-4012

State File No. 17281

Registrar's No.

1. PLACE OF DEATH:
(a) County: ATCHISON
(b) City or town: ROCK PORT
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: ATCHISON 3
(c) City or town: ROCK PORT
(If outside city or town limits, write "RURAL")
(d) Street No.: 1
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: MAGGIE MAY BROUGHT
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: FEMALE 1
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: 7 (Month) 11 (Day) 1878 (Year)

8. AGE: Years 65 | Months 9 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace: CLINTON CO (City, town, or county) MO 0 (State or foreign country)
10. Usual occupation: HOUSE WIFE
11. Industry or business .....

MOTHER FATHER
12. Name: DANIEL ASBURY
13. Birthplace: UNKNOWN (City, town, or county) MO 0 (State or foreign country)
14. Maiden name: SARAH MADDOCK
15. Birthplace: UNKNOWN (City, town, or county) MO 0 (State or foreign country)

16. (a) Informant: Mabel Long
(b) Address: Rock Port, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 4-29-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: LINDEN CEM.
18. (a) Signature of funeral director: Bartholomew Mortuary
(b) Address: Rock Port, Mo
19. (a) April 28 1944 (Date received local registrar) (b) Mrs Herbert Townsend (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April, day 27, year 1944, hour 3, minute 30 P. M.
21. I hereby certify that I attended the deceased from Jan. 14, 1944, to April, 27, 1944; that I last saw her alive on April, 27, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of gall bladder	6 Mo.
Due to: Cholelithiasis	2 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

46 f

Major findings: Of operations: Carcinoma of gall bladder
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? (Specify type of place)
While at work? Means of injury: 0

23. Signature: G. A. Reutter M.D. (M. D. or other)
Address: Rock Port, Mo. Date signed: 4/27/44

1335

(Licensed Embalmer's Statement on Reverse Side)

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

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 Gary Bartholomew

Licensed Embalmer No. 3173

P. O. Address Rock Port, 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.