

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution 16 years  
In this community 16 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline  
(c) City or town Slater  
(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 Nettie Belle Tennill

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 Marion W Tennill 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased April, 7, 1889  
(Month) (Day) (Year)

8. AGE: Years 55 Months 2 Days 29 If less than one day 0 hr. min.

9. Birthplace Saline County (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business Housekeeping

MOTHER FATHER { 12. Name Zac. D. Wood  
13. Birthplace Virginia (State or foreign country) 1  
14. Maiden name Don't know  
15. Birthplace Don't know (City, town, or county) (State or foreign country) 9

16. (a) Informant Marion W. Tennill  
(b) Address Slater Mo.

17. (a) Daves Cemetery So. of Slater Mo. (b) Date thereof 7-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial  
(d) Signature of funeral director Jones and Salzer

(e) Address Slater Mo.

19. (a) July 11 - 1944 (b) Mrs. John Giger  
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8  
year 1944 hour 8.20 P.M. minute 0 M.

21. I hereby certify that I attended the deceased from July 6, 1944 to July 6, 1944  
that I last saw her alive on July 6 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the Uterus with metastasis thru out pelvis  
Duration 1 1/2 yrs.

Due to .....  
Due to .....  
Other conditions (Include pregnancy within 3 months of death) H&H

Major findings: Of operations .....  
Of autopsy .....  
PHYSICIAN H&H  
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) .....  
Means of injury .....  
23. Signature O. M. Surrency (M. or other) Mo.  
Address Slater, Mo. Date signed 7-7-44

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

7  
2  
1

RECEIVED

District Health Office No. \_\_\_\_\_

Series File Number \_\_\_\_\_

Date Filed 8-8-44

**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 \_\_\_\_\_

Licensed Embalmer No. 1831

P. O. Address Slater 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.**