

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kennett City

(c) Name of hospital or institution K. E. Bent Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution few hrs
(Specify whether)

In this community 30 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kennett City
(If outside city or town limits, write "RURAL")

(d) Street No. 3200 Northledge
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ORABELL DEFFENBAUGH

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color of race W

6. (a) Single, widowed, married, divorced Widowed

(b) Name of husband or wife Hamilton Deffenbaugh

(c) Age of husband or wife if _____ years

7. Birth date of deceased April 21 - 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 13
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Joseph B. Parish

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

14. Maiden name Miss C. Hobbs

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

16. (a) Informant Mrs Julia Testers

(b) Address Ext Morgan Co

17. (a) Burial, cremation, or removal Burial
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Midmore Mo

18. (a) Signature of funeral director J. E. Brown

(b) Address Mo

19. (a) 9-9-44 (Date received local registrar)

(b) J. E. Brown (02) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 4
year 1944 hour 2:50 minute P. M.

21. I hereby certify that I attended the deceased from Deputy Coroner, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death dissecting aneurysm of the aorta

Due to _____

Due to 30 d

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

Major findings: Of operations _____

Of autopsy see above

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 J. E. Brown (M. D. or other) _____

Address 23rd & Mt. Com Date signed 9/7/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Dwight L. [Signature]

Licensed Embalmer No..... *4723*

P. O. Address..... *KC 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.