

Registration District No. 248

Primary Registration District No. 5844

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Newton  
 (b) City or town Seneca Rural - 5 Mi. N. E. Seneca  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: sup  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 18 yrs  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73  
 (c) City or town Seneca Mo Rural 9  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5 Mi N.E. of Seneca  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Mary Louisa McNary

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, WIDOWED  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar. 25th 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>8</u>	<u>-</u>	hr. _____ min. _____

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
 12. Name James Smith  
 13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace " 9  
(City, town, or county) (State or foreign country)

16. (a) Informant James L. Mc. Mary  
 (b) Address Seneca Mo Rt 2

17. (a) Burial (b) Date thereof Nov 27 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burkhart Cem Racine Mo

18. (a) Signature of funeral director Col. Rose

(b) Address Seneca Mo

19. (a) 12-29-1944 (b) Nettie Morris  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25th  
 year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 1939 to Nov 25 1944  
 that I last saw her alive on Oct 29 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 3 yrs  
Rheumatism 5 yrs.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 93d  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 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?

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature John B. Roberts (M. D. or other) D.O.  
 Address P.O. Box 294 Seneca Mo. Date signed Dec. 5 - 1944

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

1352

RECEIVED JAN 10 1945  
District Health Officer No. \_\_\_\_\_  
District File Number: 1244-269  
Date Filed: JAN 12 1945

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: *Corley Thompson*  
Licensed Embalmer No. 3259  
P. O. Address: *Neesho, 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.

State File No. Jan  
Registrar's No. \_\_\_\_\_

Registration District No. 248

Primary Registration District No. 5844

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

**1. PLACE OF DEATH:**

(a) County Newton

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

**3. (a) PRINT FULL NAME** Mary L. Mc hary

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 25  
(Month) (Day) (Year)

**8. AGE:** Years 74 Months 8 Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ min.

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

10. Usual occupation Skilled wife

11. Industry or business House keeping

**MOTHER FATHER**

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 5  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

S-41730 1944