

FILED MAR 3 1945

State File No. _____

Registration District No. 28

Primary Registration District No. 3006

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community _____
years, months or days)

3. (a) PRINT

FULL NAME Mary Elizabeth Dennis

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 Clarence 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 11 15 _____ hr. _____ min.

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

10. Usual occupation Farm wife

11. Industry or business _____

MOTHER FATHER

12. Name Frank Spicer
13. Birthplace M Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Maude Weatherford
15. Birthplace _____ Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant (pt) Mary Elizabeth Dennis
(b) Address Anabel, Missouri

17. (a) Burial (b) Date thereof 1-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarence, MO

18. (a) Signature of funeral director William Barkley
(b) Address Clarence, MO

19. (a) 1-13-1945 Edna H. Barber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon 61
(c) City or town Anabel (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13
year 1945 hour 12 minute 35 A.M.

21. I hereby certify that I attended the deceased from January 8, 1945, to Jan 13, 1945;
that I last saw her alive on January 13, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Retropneumonia 3 months
Duration
Due to Tbc

Due to _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Other conditions Cachexia
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy gross abscess mobile bony metastases
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, all 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 _____
3. Signature Arthur J. Barber (M. D. or other)
St. Louis Cancer Hospital Date signed 1/13/45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-2-45

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 Cliff Hawkins

Licensed Embalmer No. 2498

P. O. Address Shelburne, 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.

Registration District No. 38

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Six days
(Specify whether years, months or days)

In this community DENNIS

3. (a) PRINT FULL NAME Mary E. Dennis

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 m

6. (b) Name of husband or wife Clarence Dennis

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 18 1918
(Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days _____ If less than one day, hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Frank Spicer

13. Birthplace Shelby Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Maude Weatherford

15. Birthplace Shelby Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Elizabeth Dennis

(b) Address Route #1 Anabel, Mo.

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 Missouri (b) County Macon

(c) City or town Route #1 Anabel, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Year 1968 and _____ minute _____ M.

21. I hereby certify that I attended the deceased from January 13, 1968 to January 13, 1968

that I last saw him/her alive on January 13, 1968 and that death occurred on the date and hour stated above.

Immediate cause of death Secondary effect of large, wall-to-wall left pleural mass E. lungs

Due to pulver abscess which, tuberculous, also in left

Due to immature bone

Other conditions ADDITIONAL
(Include pregnancy within 3 months preceding death)

Major findings: ON 8 INFORMATION a tube-ovarian cystectomy was removed - pelvic inf. disease exp. not tuberculous.

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 R. S. Swick (M. D. or other) _____
Address State Cancer Hospital Date signed 1/13/68
Columbia, Missouri.

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

SUPPLEMENTAL

INT. 13

S-5521 1945