

FILED APR 19 1945  
Registration District No. 3/16

Primary Registration District No. 6069

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

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Rural; Iron Imp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: life  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
(c) City or town Rural 98  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1 mile West of Bismarck 2  
(If rural, give location)  
(e) Citizen of foreign country? no 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Mary Ann Devine

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex fem 5. Color or race white

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

6. (b) Name of husband or wife Wm. T. Devine

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased April 2 1859  
(Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 16 If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Irondale Missouri 1  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER }  
12. Name Ruben Wilson  
13. Birthplace Atlanta Georgia 1  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Niel Devine  
(b) Address Bismarck Missouri  
burial (b) Date thereof 3-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bismarck Mo.

18. (a) Signature of funeral director White & Hill  
(b) Address White Bismarck Mo.  
19. (a) 3-19-45 (b) J. J. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18  
year 1945 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from 2-10  
1945 to 3-18 1945  
that I last saw him alive on 3-19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death bronchial asthma  
Due to senility  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy 112

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? \_\_\_\_\_ (c) Means of injury 0  
23. Signature Jas W. Hulman (M. D. or other) \_\_\_\_\_  
Address Bismarck Mo Date signed 3/18/45

1575

District Health Officer No. 4  
District File Number 445-509  
Date Filed 4-17-45

**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 Paul White  
Licensed Embalmer No. 3012  
P. O. Address Boston, Mass.

**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.**