

**FILED** SEP 21 1945  
Registration District No. **212**

Primary Registration District No. **5642**

Registrar's No. **40**

1. PLACE OF DEATH:

(a) County Lafayette (Middleton)  
(b) City or town Rural (Middleton)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community approx 6 yrs (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Steele  
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 widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 14 1857  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 11 28 hr. \_\_\_\_\_ min.

9. Birthplace Ralls Co. MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

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

MOTHER FATHER  
12. Name William Blanchard  
13. Birthplace England 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Amanda Jane Steele  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. News  
(b) Address Waverly, Mo.

17. (a) Burial (b) Date thereof Aug 14 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waverly Cem.

18. (a) Signature of funeral director Waverly, Mo.

(b) Address Waverly, Mo.

19. (a) 8-13-1945 (b) Dr. W. A. Braetley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Rural - Dover 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 no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
year 1945 hour 9 minute 1 M.  
21. I hereby certify that I attended the deceased from 2-26 1945 to Aug 12 1945;  
that I last saw her alive on Aug 12 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular Renal disease  
Duration 8 mo

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

Major findings: Of operations 13/10  
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? \_\_\_\_\_

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

23. Signature Geo A Kelling (M.D. or other)  
Address Waverly, Mo. Date signed 8-13

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-10-75

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, ~~only~~ \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Forrest S. Hooper

Licensed Embalmer No. 4355

P. O. Address Higginsville, 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.