S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33549

Registration District No. 73 Primary Registration District No. 3014 Registrar's No. 111

24
2
1

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:
217 N. Lightburn St. 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 13 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town Liberty 2
(If outside city or town limits, write "RURAL")

(d) Street No. 217 N. Lightburn St 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country No

3. (a) PRINT FULL NAME Viola Hershey

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife James Hershey

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased June (Month) 24 (Day) 1900 (Year)

8. AGE:

Years	Months	Days	If less than one day
45	3	15	hr. min.

9. Birthplace Keytesville (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At home

FATHER
12. Name M. P. Chrane
13. Birthplace Cheriton Co. (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Cynthia Graham
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant James Hershey
(b) Address 217 N. Lightburn St. Liberty

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/11/45 (Month) (Day) (Year)
(c) Place: burial or cremation Keytesville, Mo.

18. (a) Signature of funeral director O.J. Carder Jr.
(b) Address 119 E. Franklin St. Liberty

19. (a) Oct 10-45 (Date received local registrar) (b) Minnie Haynes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1945 hour 8 minute 55 A. M.

21. I hereby certify that I attended the deceased from Aug 5 1945, 19__, to ____, 19__;
that I last saw her alive on Oct 9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular renal syndrome about 1 year

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 13/W

Duration

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 Wm H Goodson MD (M. D. or other)

Address Liberty Mo Date signed 10/10/45

1412 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 11-6-45

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 O. J. Carder Jr

Licensed Embalmer No. 3934

P. O. Address Liberty, 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.