

No. 2
-8-43
-17-39
X37823

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED MAR 12 1946 STANDARD CERTIFICATE OF DEATH

State File No. **5410**
Registrar's No. **182**

Registration District No. **140** Primary Registration District No. **5542**

1. PLACE OF DEATH:
(a) County **Howard**
(b) City or town **Higbee Mo. Rural**
(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 **8mo 5da**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Howard**
(c) City or town **Higbee Mo. Rural**
(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.

3. (a) PRINT FULL NAME **Jeanette Louise Avery**

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 **Single**

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **19 1945** years

7. Birth date of deceased **June 19 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 8 5 hr. min.

9. Birthplace **Moberly Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Aubrey Avery**

13. Birthplace **Higbee Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Frances Porter**

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

16. (a) Informant **Aubrey Avery**

(b) Address **R. F. D. Higbee Mo.**

17. (a) **Burial** (b) Date thereof **Feb 27 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Myres Chapel.**

18. (a) Signature of funeral director **Joe W. Burton**

(b) Address **Higbee Mo.**

19. (a) **3-2-46** (b) **Anna P. Furdell**
(Date received local registrar) (Registrar's signature)

123 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **26**
year **1946** hour **9** minute **30** a.m.

21. I hereby certify that I attended the deceased from **Feb 2 1946** to **Feb 8 1946**
that I last saw her alive on **Feb 8 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **insufficient pulmonary circulation**
Duration **1 hr**

Due to **Potent foramen ovale** **8mo 5hr**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **1572**
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 **21**

Signature **V. Robinson** (M. D. or other) **PC**

Address **Higbee, Mo** Date signed **3-2-46**

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-8-46

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 _____

Not Embalmed.

Licensed Embalmer No. _____

P. O. Address _____

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.