

No. 2
M-2-43
5-17-39
I X3589

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 23 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8155**

Registration District No. **324**

Primary Registration District No. **3072**

Registrar's No. **20**

1. PLACE OF DEATH:
 (a) County Saline
 (b) City or town Marshall
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Reception Home for Invalids 324 E. North St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 da
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Saline
 (c) City or town Miami
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ANNIE BLANCHARD RUDD
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 3
 year 1946 hour 10 minute 45 A.M.
21. I hereby certify that I attended the deceased from Jan 1 - 1946
 _____, 19____ to Feb 3, 1946
 that I last saw her alive on Feb 2, 1946
 and that death occurred on the date and hour stated above.

4. Sex Female **5. Color or** br **6. (a) Single, widowed, married,**
 race br divorced Widowed
6. (b) Name of husband or wife James Lewis Rudd **6. (c) Age of husband or wife if**
aug - 16 - 1877 alive _____ years
7. Birth date of deceased (Month) (Day) (Year)

Immediate cause of death Intestinal CARCINOMA

8. AGE: Years 68 Months 5 Days 17 If less than one day
 hr. _____ min. _____

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Saline Co Mo
 (City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Major findings: Intestinal carcinoma
 Of operations _____
 Of autopsy _____

11. Industry or business _____
12. Name Frank Drinkard
13. Birthplace Calloway Co Mo
 (City, town, or county) (State or foreign country)
14. Maiden name Margaret Jane White
15. Birthplace Calloway Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant John Lewis Drinkard
(b) Address Mapleton Kans R1
17. (a) Burial **(b) Date thereof** 2-5-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation miami mo

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 _____

18. (a) Signature of funeral director Harry Herschberger
(b) Address Marshall Mo
19. (a) 2/8/46 **(b) Mrs. G. Sewellbrook**
 (Data received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Address Marshall Mo **Date signed** 2/8/46

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

7
1
2

7
1
2

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

312-42

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 _____

Harry Hershberger

Licensed Embalmer No. _____

4357

P. O. Address _____

Marshall 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.