

FILED OCT 17 1946

Registration District No. 1

Primary Registration District No. 5003

Registrar's No. 380

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Stahl

(c) Name of hospital or institution: R. R. #2
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution None
(Specify whether in this community years, months or days)

Most of Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. R. R. #2
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Anna Belle Redix

(b) If veteran, name war _____

(c) Social Security No. None

4. Sex Female 5. Color or race White

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: April 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 13
If less than one day hr. min.

9. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Joseph Van Sickel

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Sarah E. Burnett

15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Forest Redix

(b) Address Stahl, Missouri

17. (a) Burial (b) Date thereof 9/19/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Grove Cmt.

18. (a) Signature of funeral director D. W. Riley

(b) Address Kirksville, Mo.

19. (a) 10-7-46 (b) Walter Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17
year 1946 hour 9:00 minute A: M.

21. I hereby certify that I attended the deceased from Sept 12
1946 to Sept 17 1946
that I last saw her alive on Sept 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid fever
of spring (Pate disease) 30 yrs
Duration

Due to _____

Due to _____

Other conditions 16
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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 0

23. Signature J. S. Eastman (M. D. or other)

Address Northway Mrs. Date signed 9/19/46

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

31397

RECEIVED
District Health Officer No. 70
District File Number 10-46-1919
Filed OCT 15 1946

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 DEE Riley
Licensed Embalmer No. 4181
P. O. Address Kennellwood

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.