

Registration District No. **38** Primary Registration District No. **3006**

1. PLACE OF DEATH:
 (a) County **Boone**
 (b) City or town **Columbiana**
 (c) Name of hospital or institution: **104 Raspberry**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether in this community _____ in years, months or days)

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

3. (a) PRINT FULL NAME **Jeannette Mock**
3. (b) If veteran, name war **Name** **3. (c) Social Security No.** **Name**
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 **July 14 - 1862**
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.**, day **20** - year **1946** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from **11-18** - **1946** to **11-20** - **1946**
 that I last saw him alive on **11-19** - **1946** and that death occurred on the date and hour stated above

8. AGE: Years **84** Months **4** Days **6** If less than one day _____ hr. _____ min.

Immediate cause of death **Coronary artery** **thrombosis** **for days** **Duration** _____
 Due to **Hardened Arteries**

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

Due to _____
 Other conditions **83A**
 (Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

MOTHER FATHER
11. Industry or business **Home**
12. Name **John C. Cooper**
13. Birthplace **Mo.**
 (City, town, or county) (State or foreign country)
14. Maiden name **Chara Price**
15. Birthplace **Mo.**
 (City, town, or county) (State or foreign country)

Major findings: **name**
 Of operations _____
 Of autopsy **name**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **J. A. Carnwell**
(b) Address **Bronson Mo.**
17. (a) Removal **Bronson Mo.** **(b) Date thereof** **11/20/46**
 (Burial, cremation, or removal) (Monthly) (Day) (Year)
(c) Place: burial or cremation **Bronson Mo.**
18. (a) Signature of funeral director **J. W. Stegner**
(b) Address **Bronson Mo.**
19. (a) 11-21-46 **(b) Mrs. R. E. Palmer**
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **No**
(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? **No** (Specify type of place) **(e) Means of injury** _____
23. Signature **W. A. Nye** (M. D. or other) **M.D.**
Address **Columbiana Mo.** **Date signed** **11-20-46**

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

4

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

11-26-46

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

working under my personal supervision.

Registered Apprentice No.

Signed *James W. Sigurd*

Licensed Embalmer No. *37800*

P. O. Address *Bronville, 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.