

FILED JAN 3 1947

Registration District No. **335**

Primary Registration District No. **4492**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Scott**
(b) City or town **Oran, Mo**
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **46 Years** (Specify whether years, months or days)

In this community years, months or days

3. (a) PRINT FULL NAME **Mary Louise Stehr**

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex **F** 5. Color or race **W** 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 **September-11th 1869**
(Month) (Day) (Year)

8. AGE: Years **77** Months **2** Days **25** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Donart Scherer**

13. Birthplace **Scott Co**
(City, town, or county) (State or foreign country)

14. Maiden name **Magdeline Bucher**

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

16. (a) Informant **Alex Stehr**

(b) Address **Oran Mo**

17. (a) Burial (Burial, cremation, or removal) **Burial** (b) Date thereof **12-10-46**
(Month) (Day) (Year)

(c) Place: burial **Catholic Angel Cem - Oran**

18. (a) Signature of funeral director **T. S. Keiser** **Oran Mo**

(b) Address **Oran Mo**

19. (a) **12/31/46** (b) **H. Lechner**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Scott**

(c) City or town **Oran**
(If outside city or town limits, write "RURAL.")

(d) Street No. **0**
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **7**
year **1946** hour **3** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **1946** to **12/7**, 19**46**
that I last saw her alive on **12/6**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Endocarditis**

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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

23. Signature **J. A. Cameron** (M. D. or other)

Address **Oran Mo** Date signed **12/31/46**

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

20
4
0

42028

RECEIVED

District Health Office No. 2

District File Number 147-5

Date Filed 1-3-47

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... Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.