

S. No. 2
M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10375**

FILED MAR 25 1947
Registration District No. **294**

Primary Registration District No. **3056**

Registrar's No. **66**

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCormick Hospital Moberly mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One Week
(Specify whether years, months or days)
In this community 69yrs 4mo 3da

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Higbee Mo
(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 Mamie L. Wilkinson

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 Widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 4 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 3 -If less than one day hr. _____ min. _____

9. Birthplace Randolph Co. (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Danile Barron

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

14. Maiden name Fannie Maxfield

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

16. (a) Informant Mrs Leonard McCully

(b) Address Higbee Mo.

17. (a) Burial (b) Date thereof Mar 11th 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cem. Higbee Mo

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

(b) Address Higbee Mo.

19. (a) Mar 19-47 (b) Leah Williams Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1947 hour I minute 20 p.m.

21. I hereby certify that I attended the deceased from February 24, 1947, to March 7, 1947 that I last saw her alive on March 7, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Influenzal Pneumonia Duration 11 days

Due to _____

Due to _____

Other conditions myocardial failure
(Include pregnancy within 7 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 W. Robinson (M. D. or other) D.O.

Address Higbee Mo Date signed 3-17-47

269 (Licensed Embalmer's Statement on Reverse Side)

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

8
1
0
3

RECEIVED
District Health Officer No. 10
District File Number 3-47-55
Date Filed MAR 24 1947

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 *Ed W. Triemoreth*
Licensed Embalmer No. *3978*
P. O. Address *W. Glasgow, 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.