

No. 2
-12-45
-17-39
X 47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12484**
Registrar's No. **544**

Registration District No. **42** Primary Registration District No. **1000**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(c) Name of hospital or institution: **Mo. Methodist**
(d) Length of stay: **2 weeks**
In this community **two weeks**

3. (a) PRINT FULL NAME **MARY ANN BRANLEY**
3. (b) If veteran **4** **3. (c) Social Security** **C**
name war No.

4. Sex **female** **5. Color or** **white** **6. (a) Single, widowed, married,** **divorced**
6. (b) Name of husband or wife **Clarence Branley** **(c) Age of husband or wife if** **58**
7. Birth date of deceased **May 12, 1887**

8. AGE: Years **59** Months **11** Days **1** If less than one day
9. Birthplace **De Kalb Co. MO**

10. Usual occupation **housewife**
11. Industry or business

12. Name **James Battarbee**
13. Birthplace **Ind!**
14. Maiden name **Sarah Robinson**
15. Birthplace **De Kalb Mo**

16. (a) Informant **Clarence Branley**
(b) Address **Mayville mo**
17. (a) Burial **(b) Date thereof** **4-14-47**
(c) Place: burial or cremation **Mayville mo**

18. (a) Signature of funeral director **John Brown**
(b) Address **Mayville mo**
19. (a) 4-21-47 **(b) E. E. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **De Kalb**
(c) City or town **Mayville**
(d) Street No. **11**
(e) Citizen of foreign country? **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **apt** day **13**
year **1947** hour **5** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **March 24, 1947** to **apt. 13, 1947**
that I last saw her alive on **apt. 13, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Severe anemia secondary**
Hemorrhage Stomach
Due to **hemorrhage**
Follicular Lymphocytoma 1-29-43
Due to **malignant**
Biopsy done X Ray followed
Other conditions **X Ray followed**
Major findings: **Biopsy 1-29-43**
Of operations **no 55**
Of autopsy **no 55**

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) **0**
(e) Means of injury
23. Signature **H. B. Savard** (M. D. or other)
Address **St Joseph Mo** Date signed **4-18-47**

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

MOTHER FATHER

382

(Licensed Embalmer's Statement on Reverse Side)

32
20
1

Duration

3 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

1870

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

John G. Brown

Licensed Embalmer No. *3933*

P. O. Address. *Maple Hill*

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.