

FILED MAY 5 1947

State File No. _____

Registration District No. 75

Primary Registration District No. 3015

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clinton
 (b) City or town Cameron
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Cosby Noors 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 years (Specify whether
 In this community 57 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 25
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Catherine B. McCulloch

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

4. Sex Fe 5. Color W 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased May 11 1868
 (Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days 15 If less than one day hr. _____ min. _____

9. Birthplace no (City, town, or county) (State or foreign country) 0

10. Usual occupation housewife

11. Industry or business _____

12. Name James Froman
 13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name Catherine B. Froman
 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Ralph McCulloch
 (b) Address Clatsburg

17. (a) Burial (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation Grant Hill
 18. (a) Signature of funeral director Jas L Martin
 (b) Address Clatsburg

19. (a) 5-10-47 (b) Wesley W. Maser
 (Date received local registrar) (Registrar's signature) 491

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
 year 1947 hour 1 minute 20 PM

21. I hereby certify that I attended the deceased from 21 April
 1947, to 26 April 1947
 and that death occurred on the date and hour stated above.
 that I last saw her alive on 25 April 1947

Immediate cause of death Chronic nephritis

Due to _____
 Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____

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 0

23. Signature Markina (M. D. or other) _____
 Address Cameron Mo Date signed 26 April 47

MOTHER FATHER

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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

Jos L Martin

Licensed Embalmer No. *4303*

P. O. Address

Plattsburg

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. *75*

Primary Registration District No. *3015*

Registrar's No. *34*

1. PLACE OF DEATH:

(a) County *Clinton*
(b) City or town *Cameron*
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether)
In this community _____ years, months or days *5yr*

3. (a) PRINT FULL NAME

Therese B. McCulloch

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 *m*

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

7. Birth date of deceased *May 11* (Month) *1907* (Day) *1897* (Year)

8. AGE: Years *86* Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) *MO* (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name *James Freeman*

13. Birthplace _____ (City, town, or county) *MO* (State or foreign country)

14. Maiden name *Catherine Freeman*

15. Birthplace _____ (City, town, or county) *MO* (State or foreign country)

16. (a) Informant *Ralph McCulloch*

(b) Address *Plattsburg*

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation *P. Hills*

18. (a) Signature of funeral director *J. S. Mark*

(b) Address *Plattsburg*

19. (a) *May 10, 1947* (Date received local registrar) (b) *Wm. Fred W. Moore* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* 24
year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death *chronic nephritis*

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 *Ira Kime* (M. D. or other)

Address *Cameron MO* Date signed *4/24/47*

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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