S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19817

State File No.

Registration District No. 322 Primary Registration District No. 4472 Registrar's No. 16

1. PLACE OF DEATH
(a) County Saline
(b) City or town Rural - Cambridge (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 10 Miles North East Slater (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether
In this community 30 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 10 Miles North East Slater (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) No
If yes, name country

3. (a) PRINT FULL NAME Rachel Catherine Day
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 Divorced
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased November 11 - 1874 (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 7 If less than one day ___ hr. ___ min.

9. Birthplace 6 Miles North Slater Mo (City, town, or county) (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name S A Webb
13. Birthplace Near Slater Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha Harris
15. Birthplace Near Slater Mo (City, town, or county) (State or foreign country)
16. (a) Informant Estell Fritsch
(b) Address Slater Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May - 20 - 47 (Month) (Day) (Year)
(c) Place: burial or cremation City Slater Mo
18. (a) Signature of funeral director Jones & Bazer
(b) Address Slater Mo
19. (a) May 21, 1947 (Date received local registrar) (b) Mrs. Earl C. Metz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th year 1947 hour 4 minute 45 P.M.
21. I hereby certify that I attended the deceased from April 30, 1947, to ___, 19__; that I last saw her alive on May 18, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hyper State Pneumonia	3 hrs
Due to Carcinoma Uterus	?
Due to Malatastes to Lung	?
Other conditions Secondary Anemia (Include pregnancy within 3 months of death)	?

Major findings:
Of operations
Of autopsy None 48B

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 None
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature N E Lockwood (M. D. or other)
Address Slater Mo Date signed 5/19/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed

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.....

Licensed Embalmer No.....

P.O. Address.....

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.