

FILED DEC 26 1947

Registration District No. 560

Primary Registration District No. 6225

Registrar's No. 186

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

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Washington Ind.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital 2
(If not in hospital or institution, write street and house location)
(d) Length of stay: In hospital or institution 10 Mo. 23 days
(Specify whether years, months or days)
In this community 10 months 23 days

3. (a) PRINT FULL NAME MARGARET RICEY

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 86 1/2 years

7. Birth date of deceased 8-26-1863
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days 24 If less than one day hr. min.

9. Birthplace Hannibal Mo
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name J. S. Smith

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

14. Maiden name Mary Lacey

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

16. (a) Informant Hospital record

(b) Address Nevada Mo

17. (a) Burial (b) Date thereof Dec 20 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Clister Missouri

18. (a) Signature of funeral director Allen G. Gage

(b) Address Nevada Mo

19. (a) 12-20-47 (b) W. Pathway
(Date received local register) (Registrar's signature) 2211

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Hallister
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. 20 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 12 day 20
year 1947 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1-27, 1947, to 12-20, 1947
that I last saw her alive on 12-19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-renal disease

Due to ✓

Due to ✓

Other conditions Severe deterioration
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 131A

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 R. G. Hall (M. D. or other) _____
Address Nevada Mo Date signed 12-20-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
DISTRICT HEALTH OFFICER No. 7,
District No. 11-41-1978
District No. 12-24-77
Date Filed

JAN 6 1968

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 Allen S. Keys
Licensed Embalmer No. 1968
P. O. Address Nevada, 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, above space should be left blank.