

No. 300
M-10-47
v. 5-17-39
I 3908

FEDERAL BUREAU OF VITAL STATISTICS
National Office of Vital Statistics
FILED NOV 12 1948
Registration District No. 190

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

33406
State File No. 11-48-124
Registrar's No. 126

Primary Registration District No. 5630

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

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

3. (a) PRINT FULL NAME Mary Magnolia Myers
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex 7 / 5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Pete Myers
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 8 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 19
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Elizabeth Hill

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

14. Maiden name Amanda Halsted

15. Birthplace Laclede Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lammie Ruble

(b) Address Lebanon Brownfield Rt.

17. (a) Burial (b) Date thereof 10-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads Cemetery

18. (a) Signature of funeral director W.E. Holman

(b) Address Lebanon Mo.

19. (a) 11-1-48 (b) Jessie B. Lynch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1948 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from July 2, 1948
19 _____ to death, 19 _____;
that I last saw her alive on October 7, 1948, 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death intestinal obstruction
incomplete Duration 2 years

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 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 Rae W. Froelich M.D. (M. D. or other)

Address Lebanon Mo. Date signed 10/27/48

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Letranon 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.