

300
0-47
7-39
3906

FILED DEC 2 1948
Registration District No. 71

Primary Registration District No. 3012

State File No. _____
Registrar's No. 157

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town EXCELSIOR SPRINGS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
EXCELSIOR SPRINGS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS
(Specify whether years, months or days)

In this community 2 YEARS
years, months or days

3. (a) PRINT FULL NAME MARY LOU DALLAS

3. (b) If veteran, name war NONE

3. (c) Social Security No. UNKNOWN

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHN DALLAS

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased APRIL 16 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

57 6 23 hr. 1 min.

9. Birthplace CARROLL COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business NONE

MOTHER FATHER { 12. Name GEORGE JONES

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

14. Maiden name VIOLET WHEELER

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

16. (a) Informant Lena Eckhart

(b) Address Keany, Mo.

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

(c) Place: burial or cremation EVERGREEN CEM. MO.

18. (a) Signature of funeral director Clayton P. ...

(b) Address Excelsior Springs, Mo.

19. (a) 11/9/48 (b) Barolaine Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 24

(c) City or town EXCELSIOR SPRINGS 1
(If outside city or town limits, write "RURAL")

(d) Street No. 214 N. MAIN STREET 1
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 9
year 1948 hour 12:25 minute _____ P.M.

21. I hereby certify that I attended the deceased from
Nov. 7, 1948, to Nov. 9, 1948;
that I last saw her alive on Nov. 9, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 das

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 Dr. M. ... (M. D. or other) MD

Address Excelsior Springs, Mo. Date signed 11-9-48

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-1-48

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 _____

Lindell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.