

FILED OCT 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

34534

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 245 PRIMARY REG. DIST. NO. 3047 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>NEWTON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>NEWTON</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Neosho</u>		c. LENGTH OF STAY (in this place) <u>( )</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FAIRVIEW</u>		d. STREET ADDRESS (If rural, give location) <u>5</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SALE MEMORIAL Hosp.</u>								
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY LAVINA</u> b. (Middle) <u>MARRS</u> c. (Last) <u>MARRS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 17 1949</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 27 1859</u>	9. AGE (In years last birthday) <u>89</u>	if UNDER 1 YEAR Days <u>10</u>	if UNDER 24 HRS. Hours <u>20</u>	Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>TAYLORVILLE ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JOHN CASEY</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET HILL</u>		14. NAME OF HUSBAND OR WIFE <u>C.J. MARRS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>OPAL RUSSELL Neosho Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture of R hip</u> DUE TO (c) <u>arterial sclerosis</u>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>NEOSHO</u> (STATE) <u>MO.</u>		INFORMATION REQUESTED		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>8-16-1949 12:12 a.</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down stairs</u>				
22. I hereby certify that I attended the deceased from <u>8-21-1949</u> , to <u>9-17 1949</u> , that I last saw the deceased alive on <u>9-17-1949</u> and that death occurred at <u>1:20 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Paul C Davis M.D.</u> (Degree or title)				23b. ADDRESS <u>Neosho Mo.</u>		23c. DATE SIGNED <u>9/19/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Sept. 19, 1949</u>		24c. NAME OF CEMETERY OR CREMATORIUM <u>Truce Green</u>		24d. LOCATION (City, town, or county) (State) <u>Boulden City Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Oct. 11, 1949</u>		REGISTRAR'S SIGNATURE <u>Melvin C. Barrman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thompson Funeral Home</u>		ADDRESS <u>Neosho, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

RECEIVED

District Health Officer No. NEWTON Co. HEALTH UNIT  
District File Number 1049-182  
Date Filed OCT 19 1949

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Stollie Kessel*

Licensed Embalmer No. 4690

P. O. Address Newton, Missouri

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.