No. 1
2-43
17-39
X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 26725

FILED AUG 20 1945

Registration District No. 11 — Primary Registration District No. 4023 — Registrar's No. 49

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Exeter
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 80 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Barry 5
(c) City or town Exeter 2
(If outside city or town limits, write "RURAL")
(d) Street No. 6
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary ANTLE
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 William B Antle
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August (Month) 2 (Day) 1846 (Year)

8. AGE: Years 98 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Carroll Co. (City, town, or county) Ark. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER
12. Name John Clark
13. Birthplace Ark. (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Eliza Savage
15. Birthplace Ark. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Myrtle Bayliss
(b) Address Exeter, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Maplewood Cem.
18. (a) Signature of funeral director Blankenships
(b) Address Monett, Mo.
19. (a) July 28-1945 (Date received local registrar) (b) Grace Williams (Registrar's signature)

10-17

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour 5 minute P. M.
21. I hereby certify that I attended the deceased from July 1st, 1945, to July 24, 1945, that I last saw h alive on July 23rd, 1945, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Uremia | 5 days |
| Due to: Senility | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: | |
| Of autopsy: | |

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Dean Dawson (M. D. or [illegible])
Address Cassville, Mo. Date signed 7-26-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 845-890
Date Filed AUG 14 1945

## 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 L. H. Blankenship

Licensed Embalmer No. 2397

P. O. Address Monett, 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.**

s: No. 2B
5M—3-45
I X43880

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 11 Primary Registration District No. 4023 Registrar's No. 49

1. PLACE OF DEATH
(a) County Barry
(b) City or town Exeter
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

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

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Aug (Month) 2 (Day) (Year)

8. AGE: Years 98 Months 11 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ark (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 24 day
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to Chronic nephritis ✓ | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Leslie Mauzman (M. D. or other)
Address Cassville, Missouri Date signed 8-25

S-26725