

FILED JUN 28 1946

Registration District No. 175

Primary Registration District No. 5649

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawerance
(b) City or town "RURAL"
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3 mi. NE of Monett, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 6 mo. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawerance 55
(c) City or town "RURAL" 0
(If outside city or town limits, write "RURAL")
(d) Street No. 3 mi. NE of Monett, Mo. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mollie MAY

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 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased April 8, 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 1 If less than one day -- hr. --- min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robinson

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

14. Maiden name Edison

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

16. (a) Informant Orbin May

(b) Address Monett, Mo. Rt. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/1946 (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Cemetary

18. (a) Signature of funeral director H. C. Koon

(b) Address Cassville, Mo.

19. (a) 7-13-46 (Date received local registrar) (b) Orbin May (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9th. year 1946 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from 1943 to June 8, 1946
that I last saw her alive on June 8, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 930

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 Glenn T. Salver (M. D. number MD)
Address Cassville, Mo. Date signed June 11

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

MOTHER FATHER

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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 *J. C. Canada*
Licensed Embalmer No. *4196*
P. O. Address *Cassville, 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.

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3880

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 175

Primary Registration District No. 5649

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Rural
(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 _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mollie May

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

7. Birth date of deceased Apr.
(Month) (Day) (Year)

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country) Tenn

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) July 13-1946 (b) Osa Mae Hall
(Data received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

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

20896