REG'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14940
Do not use this space.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH
(a) County GRUNDY
(b) Township Jefferson
(c) City HICKORY
Registration District No. 328
Primary Registration District No. 5461
Registered No.
(d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MAHALIE ANN IRVIN
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF JOHN W IRVIN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-16-1863

7. AGE: YEARS 75 | MONTHS 4 | DAYS 15 | If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LIVINGSTON COUNTY Mo

FATHER
13. NAME A. M. DOCKERY
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LIVINGSTON COUNTY Mo

MOTHER
15. MAIDEN NAME ELIZABETH DOCKERY
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LIVINGSTONE COUNTY Mo

17. INFORMANT (ADDRESS) J. A. Irvin Spickard Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE SHELBURNE GRUNDY COUNTY DATE 3/3 1939

19. FUNERAL DIRECTOR (NAME) Chas C. Schooler
(ADDRESS) Spickard Mo

20. FILED 3-3 1939 Gene D. Faw
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mch-1- 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1939, to March 1-, 1939
I last saw her alive on Feb 16, 1939. Death is said to have occurred on the date stated above, at 5:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Intra-capsular fracture left femur (left)	2-14-39

Other contributory causes of importance:
Deceased was a paralytic

Name of operation None Date of
What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 2-14, 1939
Where did injury occur? Her home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Her home
Manner of injury Fell on floor
Nature of injury Fracture of femur

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) C. H. Mullen, M. D.
(Address) Trenton Mo

300

Licensed Embalmer's Statement on Reverse Side)

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, Ross Wise

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.