

Registration District No. 539

Primary Registration District No. 4320

1. PLACE OF DEATH:

(a) County MADISON
(b) City or town MARION MO
(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

FRY MISSOUR KOLLOY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE

5. Color or race W

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

6. (b) Name of husband or wife EDDIE KOLLOY

6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased _____

(Month) 4

(Day) 5

(Year) 1861

8. AGE:

Years 78

Months 4

Days 12

If less than one day _____ hr. _____ min.

9. Birthplace MARION MO

(City, town, or county)

(State or foreign country)

10. Usual occupation HOUSE-WORK

11. Industry or business _____

12. Name ISAC-MOYORS

13. Birthplace MARION MO

(City, town, or county)

(State or foreign country)

14. Maiden name SARAH-CAMBS

15. Birthplace MARION MO

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Octa Roman

(b) Address MARION MO

17. (a) BURIAL

(b) Date thereof 8-18-1939

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation Rhodas, CHAP COM GEMRY

18. (a) Signature of funeral director Roman

(b) Address Marion Mo

19. (a) Aug 18-1939

(b) S. A. Slaughter

(Date received local registrar)

(Registrar's signature)

Ray E. S. Slaughter

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MADISON
(c) City or town MARION
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 17 - ~~1939~~
year 1939 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 7,
1939, to Aug 16, 1939
that I last saw her alive on Aug 16, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Emphysema of right lower extremity

Due to

Diabetes Mellitus and infection between 5th and 4th toes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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 6 M Scott (M.D. or other) A.O.
Address Marion, Mo Date signed 8-18-39

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.

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.....

Myron P. LaPee, Registered Apprentice No.....
working under my personal supervision.

Signed *Myron P. LaPee*
Licensed Embalmer No. *4025*
P. O. Address *Fredrickstown*

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, above space should be left blank.