

1. PLACE OF DEATH:

(a) County Davies County

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2 miles N.W. LockSprings, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether in this community. Forty years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Davies County

(a) State Missouri (b) County Davies

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 2 miles N.W. LockSprings, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Elizabeth Eads 320

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21-1940
year 1940 hour _____ minute 0 M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife N.M. Eads 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased August 5 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 20, 1940 to May 21, 1940
that I last saw her alive on May 21, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

55 9 17 hr. 58 min.

Immediate cause of death Cystitis Duration _____

9. Birthplace Davies County Missouri
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Housewife

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

11. Industry or business _____

Major findings: Of operations ✓

MOTHER FATHER { 12. Name William A. Grimes

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

Of autopsy ✓

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 14. Maiden name Sarah Burton

15. Birthplace Davies County Missouri
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant's own signature Newt M. Eads

(b) Address R. F. D. LockSprings, Mo.

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 5-24-'40
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation LockSprings (mo.) Cem.

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director F. B. Norman 230

(b) Address Chillicothe, Mo.

23. Signature W. H. Minnich (M. D. or other) _____

Address Lock Springs Date signed 5/21/40

19. (a) May 23/40 (b) W. H. Minnich
(Date received local registrar) (Registrar's signature)

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

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.

RECEIVED
District Health Officer No. 11,
District File Number 640-923
Date Filed JUN 13 1940

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.....
Elton F. Norman & E. R. Norman (2374), Registered Apprentice No.....
working under my personal supervision.

Signed.....

Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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, above space should be left blank.