

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.

Registration District No. 7091619

Primary Registration District No. 3038

Registrar's No. 90

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Saline
 (c) City or town Marshall
 (If outside city or town limits, write "RURAL")
 (d) Street No. 680 N Morgan
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME SUSAN FRANCIS NUNN
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 3
 year 1940 hour 5:00 minute _____ P. M.

4. Sex Female 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 16 - 1856
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1940 June 3
 that I last saw her alive on June 2 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
83 8 17 _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage Duration 24 h.
 Due to Atherosclerosis 29 yr.

9. Birthplace Dallas Co. MO
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Other conditions _____ (Include pregnancy within 8 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

11. Industry or business _____
 MOTHER FATHER { 12. Name Samuel Hyde
 13. Birthplace Unknown
 14. Maiden name Andie Breeze
 15. Birthplace Unknown

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 _____

16. (a) Informant's own signature Mrs E. F. Hardison
 (b) Address 680 N Morgan Marshall MO
 17. (a) Burial (b) Date thereof 6-5-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Urbana MO
 18. (a) Signature of funeral director Harry Hershberger
 (b) Address Marshall MO
 19. (a) 6-3-40 (b) Mary Kent
 (Date received local registrar) (Registrar's signature)

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

23. Signature [Signature] (M. D. or other)
 Address Marshall MO Date signed 6/4/40

11-11-40

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-11-40

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 Felix Benz
Licensed Embalmer No. H127
P. O. Address Marshall, 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.