

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.

10 AUG 16 1940

549

Primary Registration District No.

5742

Registrar's No.

1. PLACE OF DEATH:  
 (a) County Marion Co., Missouri  
 (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

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Marion  
 (c) City or town Rural  
(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.

3. (a) PRINT FULL NAME NANCY S. MORRIS  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 7 day 17  
 year 1940 hour 2 minute 30 A. M.  
 21. I hereby certify that I attended the deceased from Aug 1  
 \_\_\_\_\_, 1933, to July 17, 1940  
 that I last saw her alive on July 17, 1940  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death Carcinoma of stomach  
 Duration unknown

7. Birth date of deceased Jan 21 1833  
(Month) (Day) (Year)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years 85 Months 5 Days \_\_\_\_\_  
If less than one day 26 hr. 0 min.

9. Birthplace Marion Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
 12. Name William Stevenson  
 13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
 14. Maiden name Susan Ragar  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature \_\_\_\_\_  
 (b) Address \_\_\_\_\_

17. (a) Ragar Cem. (b) Date thereof 7-18-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Ragar Cemetery

18. (a) Signature of funeral director B. M. Allie  
 (b) Address Philadelphia, Missouri

19. (a) July 18 (b) Walter Helemat  
(Date received local registrar) (Registrar's signature)

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?  
4AD While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
 (e) Means of injury \_\_\_\_\_  
 Signature Dr. C. E. Shriver (M. D. or other) Dr.  
 Address Philadelphia Mo Date signed 7/18/40

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

**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 *D. M. Allen*.....

Licensed Embalmer No. *2437*.....

P. O. Address.....

**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.**