

Registration District No. 626

Primary Registration District No. 5827

Registrar's No. 92

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Rural Polk Township
(c) Name of hospital or institution: Nodaway County Infirmary 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 yrs.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nodaway
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 4 1/2 mi. west of Maryville
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MARY BAUGHMAN 255

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife not known 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased apr (Month) 4 (Day) 1864 (Year)

8. AGE: Years 78 Months 3 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Graddyville Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name John Faylier

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

14. Maiden name Sarah Fraser

15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Records
(b) Address County Farm

17. (a) Burial (b) Date thereof July 21, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clearmont, Mo

18. (a) Signature of funeral director John W. Price
(b) Address Maryville Mo.
19. (a) 7-21-1940 (b) Marion E. Clardy
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 1 minute 0 A.M.

21. I hereby certify that I attended the deceased from Mat's M
1940 to July 19, 1940
that I last saw her alive on July 19
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Duration
Interstitial Nephritis 5 yrs

Due to arteriosclerosis
malnutrition

Due to _____

Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations _____

Of autopsy _____

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?
556 (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature B. G. Cassino (M. D. or other) _____
Address Maryville Mo. Date signed 7/20/40

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.....

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

Signed.....

John W. Price

Licensed Embalmer No. *3229.*

P. O. Address *Maryville 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.