

Registration District No. 876Primary Registration District No. 4492Registrar's No. 19

1. PLACE OF DEATH:

(a) County Scott
 (b) City or town Chaffee
 (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 ✓
 In this community 29 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Annabekke Stith 3303. (b) If veteran, name war. ✓ 3. (c) Social Security No. ✓4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife George W. Stith 6. (c) Age of husband or wife if alive 4 years7. Birth date of deceased July 4 1854
(Month) (Day) (Year)8. AGE: Years 86 Months 0 Days 13 If less than one day hr. _____ min. _____9. Birthplace Knox Co Ind.
(City, town, or county) (State or foreign country)10. Usual occupation House Keeper 9

11. Industry or business _____

12. Name Graham 113. Birthplace Don't know
(City, town, or county) (State or foreign country)14. Maiden name Sarah Wilson15. Birthplace Ind
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Lillian Dunn(b) Address Chaffee Mo.17. (a) Burial (b) Date thereof July 19 40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Union Park Chaffee Mo.18. (a) Signature of funeral director Blattlinghoff Hubbers(b) Address Chaffee Mo.19. (a) 7/19/40 (b) W. D. Rainey
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
 (c) City or town Chaffee
 (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 July day 18 1940
year 1940 hour 4:30 minute P M.21. I hereby certify that I attended the deceased from on July 12 1940 to July 12 1940that I last saw her alive on July 12 1940 and that death occurred on the date and hour stated above.Immediate cause of death SpontaneousDue to ArteriosclerosisDue to Cor. Myocarditis

Other conditions _____

(Include pregnancy within 3 months of death) ASC

Major findings: _____

Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) No

(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? 735
While at work? _____ (Specify type of place) (e) Means of injury _____23. Signature W. D. Rainey (M. D. or other) _____
Address Chaffee Mo Date signed 7/19/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 2,

District File Number 840-130

Date Filed 8/5/40

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 Minnie Bisplinghoff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.