

1940 OCT 23 1940

Registration District No. _____ Primary Registration District No. **3004** Registrar's No. **72**

1. PLACE OF DEATH:
 (a) County **Bates**
 (b) City or town **Butler**
 (c) Name of hospital or institution: _____
 (d) Length of stay: In hospital or institution _____
 In this community _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Bates**
 (c) City or town **Butler**
 (d) Street No. **409 N Main St**
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Mary Emma Herrell**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **October** day **5th**
 year **1940** hour **7** minute **20 P.** M.
 21. I hereby certify that I attended the deceased from **7-30**
 19**40** to **10-2-2-1940**
 that I last saw **her** alive on **10-2-** 19**40**
 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 **James Herrell**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **June 5 1866**
 (Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage**
 Duration _____

8. AGE: Years **74** Months **4** Days **0**
 If less than one day _____ hr. _____ min.

Due to **Septicemia 80%**
 Due to _____

9. Birthplace **Christian County Del.**
 (City, town, or county) (State or foreign country)

Other conditions **Unintended left hip fracture - (3 years)**
 (Include pregnancy within 3 months of death)

10. Usual occupation **Retired Housewife**

Major findings **Fracture - (3 years)**
 Of operation _____
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name **James Harrison**
 13. Birthplace **Wisconsin**
 14. Maiden name **Susan Amanda Cooper**
 15. Birthplace **Christian Co. Illinois**

16. (a) Informant **Mrs Harry Herrell**
 (b) Address **Butler Mo.**

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

17. (a) **Buried** (b) Date thereof **Oct 8 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Wald Hill**

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

18. (a) Signature of funeral director **C. L. Cooper**
 (b) Address **Butler Mo 53**
 19. (a) **Oct 8 1940** (b) **Miss L Cooper**
 (Date received local registrar) (Registrar's signature)

23. Signature **Arthur L. Cooper** (M.D. or other) _____
 Address **Butler Mo** Date signed **10-5-40**

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

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, ~~city~~.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *R. Denton Lill*.....

Licensed Embalmer No. 4123.....

P. O. Address Butler, 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, fact should be so stated above.