

Registration District No. 067 40 1940

Primary Registration District No. 4555

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Granby
(If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 75 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Granby Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Newton St. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9th
year 1940. hour 11 minute 40 P. M.
21. I hereby certify that I attended the deceased from Sept 9.
_____, 1940. to Sept 9, 1940.
that I last saw her alive on Sept 9, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death: Heart block

Duration

15 min.

Due to _____
Due to _____

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

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? 5/1/1
_____ (Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature R. E. Ralens (M. D. or other) _____
Address Granby Mo. Date signed 9-11-40

3. (a) PRINT FULL NAME CELIA ANN MITCHELL

3. (b) If veteran, name war 4 3. (c) Social Security No. A

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband R P Mitchell 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 7 (Month) 22 (Day) 1863 (Year)

8. AGE: Years 77 Months 1 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Huntsville Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name E. M. Mottztt.

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

14. Maiden name Elizabeth Telescoff

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

16. (a) Informant's own signature JAMES MOTTZTT

(b) Address Granby Mo.

17. (a) Burial (b) Date thereof Sept 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Granby Mo. Cemetery

18. (a) Signature of funeral director JAMES MOTTZTT

(b) Address Granby Mo.
19. (a) 9-11-40 (b) R. E. Ralens
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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.

RECEIVED

District Health Officer No. 6,

District File Number 1040-2734

Date Filed OCT 15 1940

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.....

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

Signed James Putnam.....

Licensed Embalmer No. 1917.....

P. O. Address Franklin, 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.