

FILED OCT 23 1940  
6.20

Registration District No. 6.20

Primary Registration District No. 3051

Registrar's No. 124

1. PLACE OF DEATH:

(a) County nodaway  
(b) City or town Marysville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Francis Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks  
In this community 8 yrs.  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County nodaway  
(c) City or town Marysville (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3. m. south  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23  
year 1940 hour 12 minute 10 a. M.  
21. I hereby certify that I attended the deceased from Aug 30  
1940 to Sept 23, 1940  
that I last saw her alive on Sept 22, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Carcinoma of Breast  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
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While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

28. Signature H. M. Hall Jr (M. D. or other) MD  
Address Maryville Mo Date signed 9/24/40

8. (a) PRINT FULL NAME ETHEL MAY PIATT

3. (c) Social Security No. none  
8. (b) If veteran, name war \_\_\_\_\_

4. Sex 7 6. Color or race W  
6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Albert Estell Piatt  
6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Feb. 17, 1889.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 7 16 hr. \_\_\_\_\_ min.

9. Birthplace Sentry Co. Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Albert Louis M<sup>c</sup> Reynolds  
13. Birthplace Sentry Co. Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Maria Jane Keesee  
15. Birthplace Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Rosa M<sup>c</sup> Reynolds  
(b) Address Clark Mo.

17. (a) Burial (b) Date thereof Sept 24, 1940.  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director John W. Priggs  
(b) Address Maryville Mo.

19. (a) 9-24-40 (b) Marion E. Clardy  
(Data received local registrar) (Registrar's signature)

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, 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.**