

STANDARD CERTIFICATE OF DEATH

Registration District No. **18**

Primary Registration District No. **6182**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Wash Union Mo**  
(b) City or town **Andrews**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) **20**  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

8. (a) PRINT FULL NAME **Mary Merrill**

8. (b) If veteran, name war **-** 8. (c) Social Security No. **-**

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

6. (b) Name of husband or wife **-** 6. (c) Age of husband or wife if alive **-** years

7. Birth date of deceased **Aug 29 1929**  
(Month) (Day) (Year)

8. AGE: Years **11** Months **11** Days **17** If less than one day hr. min.

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

10. Usual occupation **child**

11. Industry or business **-**

MOTHER FATHER  
12. Name **Alanzo Merrill**  
18. Birthplace **Andrews Mill Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Sarah Brooks**  
15. Birthplace **Shannon Co Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Herbert Briggs**

(b) Address **Andrews Mo**

17. (a) **Burial** (b) Date thereof **Aug 11-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Undie**

18. (a) Signature of funeral director **none**

(b) Address **818**

19. (a) **Aug 11 40** (b) **Q. F. Research**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **-**  
(c) City or town **Andrews Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **0**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? **-** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **10**  
year **1940** hour **7:0** minute **30 A** M.

21. I hereby certify that I attended the deceased from **Oct 1939** to **Aug 10 1940**  
that I last saw him alive on **Aug 10 1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Endocarditis**  
**Infected tonsils**  
Due to **115**  
Other conditions (Include pregnancy within 3 months of death) **115**

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? **-**

While at work? **-** (Specify type of place) (e) Means of injury **-**  
23. Signature **W. F. Research** (M. D. or other) **1**  
Address **Palmer Mo** Date signed **8/10/40**

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**