

Registration District No. 464 Primary Registration District No. 4277 Registrar's No. 17

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Odesa
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 62 yr. years, months or days

3. (a) PRINT FULL NAME Mayme Ann Prince
(b) If veteran, name war (c) Social Security No.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife O.B. Prince 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Jan 1 (Month) 1 (Day) 1870 (Year)

8. AGE: Years 71 Months 3 Days 25 If less than one day hr. min.

9. Birthplace: Mayview (City, town, or county) O. Mo. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Butler Moore
13. Birthplace Lexington (City, town, or county) O. Mo. (State or foreign country)
14. Maiden name Mollie Vaughn
15. Birthplace unknown (City, town, or county) NY (State or foreign country)

16. (a) Informant Mrs. G. J. Guther
(b) Address Higginsville, Mo.

17. (a) Burial (b) Date thereof Apr 27-41 (Month) (Day) (Year)
(c) Place: burial or cremation Odesa Cem

18. (a) Signature of funeral director Blaine Han
(b) Address Odesa, Mo.

19. (a) 4-27-41 (Date received local registrar) (b) Mrs. E. M. Goodwin (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Odesa (If outside city or town limits, write "RURAL")
(d) Street No. 300 Wells St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26 year 1941 hour 2 minute 07 A. M.
21. I hereby certify that I attended the deceased from Dec. 1939 to 4-26-41 1941
that I last saw him alive on 4-26 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Thrombosis of cerebral ar. Apoplexy
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____

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? 4/16
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. M. Guther (M. D. or other) 9/18/41
Address Odesa Mo Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 8,
District File Number
Date filed 5-5-41

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 *[Signature]*

Licensed Embalmer No. 2945

P. O. Address Osama, 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.