

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.

FILLED OCT 15 1941

Registration District No. 79

Primary Registration District No. 5036

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Centralia Mo R.R.
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 53 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna Ruth McColley
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Robert H McColley
6. (c) Age of husband or wife if alive deceased
7. Birth date of deceased 5-6-1862
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 18
If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business at home

MOTHER FATHER
12. Name Eliza Bruce Hudson
13. Birthplace Culpeper Va (City, town, or county) (State or foreign country)
14. Maiden name Winstona Reed
15. Birthplace Culpeper Va (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Columbus Jackson
(b) Address Centralia Mo R.R.

17. (a) Rural (b) Date thereof 9-26-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Centralia, Mo

18. (a) Signature of funeral director Fred Thompson
(b) Address Madison Mo

19. (a) 9/25/41 (b) Arthur
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 24
year 1941 hour 6 minute 7 M.

21. I hereby certify that I attended the deceased from 9/20/41 to 9/24/41
that I last saw her alive on 9/23/41
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 43N
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 Arthur (M.D. or other)
Address Centralia Mo Date signed 9/26/41

RECEIVED

District Health Officer No. 10

District File Number 10-H-1776

Date Filed DEC 8 1941

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

Mrs. Freda Thompson

Licensed Embalmer No.

3282

P. O. Address

Madison, W.

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.