

FILED OCT 27 1941

Registration District No. **373**

Primary Registration District No. **4219**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Holt
 (b) City or town Oregon
 (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)
 (d) Length of stay: In hospital or institution _____
 In this community 4 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Holt **044**
 (c) City or town Oregon
 (If outside city or town limits, write "RURAL") **0**
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary Beck Jeffrey
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 30th
 year 1941 hour 12:55 minute P. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife A. H. Jeffrey 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased September 2, 1864
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 6
1939 to Sept 30 19 41
 that I last saw her alive on Sept 29 19 41
 and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months _____ Days 28
 If less than one day _____ hr. _____ min.

Immediate cause of death Senile Dementia **2 yrs**
 Due to age
 Due to _____

9. Birthplace Oregon Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation At Home

Other conditions Chronic Myocarditis 7 yrs
 (Include pregnancy within 3 months of death)
PHYSICIAN
 Major findings: 938
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name James W. Ramsey
 13. Birthplace Pennsylvania
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah O. Jackson
 15. Birthplace Pennsylvania
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sarah E. Thornhill
 (b) Address Oregon, Missouri
 17. (a) Burial (b) Date thereof 10/3/41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Oregon, Missouri
 18. (a) Signature of funeral director James H. Pettigrew
 (b) Address Oregon, Missouri
 19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

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 James H. Pettigrew (M. D. or other) 0
 Address Oregon Mo Date signed 10-3-41

4 K 00 00

DEPT. OF HEALTH

STATE OF MISSOURI

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 James H. Pettigall
Licensed Embalmer No. 3192
P. O. Address Oregon, Missouri

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35107

Registration District No. 873

Primary Registration District No. 4219

Registrar's No.

1. PLACE OF DEATH: Walt Oregon

(a) County.....

(b) City or town.....
(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)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mary B Jeffrey

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
Year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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 Sept 2
(Month) (Day) (Year)

8. AGE: Years 77 Months - Days 23
(If less than one day) min.

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

10. Usual occupation.....

11. Industry of business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10-30-41 (Date received local registrar) [Signature] (Registrar's signature)

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

