

Registration District No. 702

Primary Registration District No. 5934

Registrar's No. 10

1. PLACE OF DEATH: Polk

(a) County Polk

(b) City or town Beaumont

(c) Name of hospital or institution: Rural 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 _____ (years, months or days)

3. (a) PRINT FULL NAME MAUD ANN AGEE

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 Married

6. (b) Name of husband or wife Lor 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Mar 31 - 1887

(Month) (Day) (Year)

8. AGE: Years 54 Months 7 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Halway mo

(City, town or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name David Gordon

13. Birthplace Bolivar mo

(City, town or county) (State or foreign country)

14. Maiden name Mary G. Miller

15. Birthplace Bolivar mo

(City, town or county) (State or foreign country)

16. (a) Informant Loriger

(b) Address Bolivar mo

17. (a) Burial (b) Date thereof Nov 5

(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director W. H. Johnson & Co

(b) Address Bolivar mo

19. (a) 11-6-41 (b) Mary Gamel

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Polk 84

(a) State Mo (b) County Polk 84

(c) City or town Rural

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

(d) Street No. 1-1/2 mile N of Highway 0

(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4

year 1941 hour _____ minute 5:10 AM

21. I hereby certify that I attended the deceased from Aug 1940 to Nov 4 1941

that I last saw her alive on Nov - 3 1941

and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure

Due to mitral insufficiency

Due to o

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 928

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. H. Johnson (M. D. or other) _____

Address Bolivar Date signed 11-4-41

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

RECEIVED

District Health Officer No. 7,

District File Number 12-41-1943

Date Filed 12-2-41

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 Frank Grable Jr

Licensed Embalmer No. 4140

P. O. Address Baliviar, Va

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, fact should be so stated above.