

FILED DEC 6 1941

Registration District No. 703

Primary Registration District No. 6006

17

1. PLACE OF DEATH

(a) County St. Clair  
(b) City or town Rural, Charleston  
(c) Name of hospital or institution: 7 mi S & W Louny City, Mo  
(d) Length of stay: In hospital or institution Life  
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair  
(c) City or town Rural  
(d) Street No. 7 mi S & W of Louny City, Mo  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Charles Maree

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 500-09-5700

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

(b) Name of husband or wife Belle Maree 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 4 11 1890

8. AGE: Years 51 Months 7 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Henry Co, Mo

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name W B Maree

13. Birthplace Kentucky

14. Maiden name Fannie Nalland

15. Birthplace Henry Co, Mo

16. (a) Informant Belle Maree

(b) Address Louny City, Mo

17. (a) Rural (b) Date thereof 11 26 41

(c) Place: burial or cremation Englewood, Clatsop Co, Ore

18. (a) Signature of funeral director Fred Wilkinson

(b) Address Clatsop, Mo

19. (a) 11/25-1941 (b) Sophia G. Stratton

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24 year 1941 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from 9-19 1941 to 11-29 1941 that I last saw him alive on 11-22 1941 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac decomposition - 5 mos.

Due to mitral Regurgitation

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? \_\_\_\_\_

(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 T. H. Jangler, Jr. (M. D. or other) M.D. Address Ocala, Mo. Date signed 11-24-41

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 12-41-1972

Date Filed 12-5-41

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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

*Fred Wilkerson*

Licensed Embalmer No. 2478

P. O. Address Clinton 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, fact should be so stated above.