

Registration District No. 824

Primary Registration District No. 6076

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Quincy, Mo  
(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)

3. (a) PRINT FULL NAME Zepher Deatherage

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

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife James Franklin Deatherage 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Mar 26 1908  
(Month) (Day) (Year)

8. AGE: Years 41 Months 7 Days 19 If less than one day hr. min.

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

10. Usual occupation Housekeeper

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Thas Tice  
13. Birthplace no data 9  
(City, town, or county) (State or foreign country)  
14. Maiden name no data  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant James Franklin Deatherage

(b) Address Quincy, Mo

17. (a) Burial (b) Date thereof 11-16-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cerary Cemetery

18. (a) Signature of funeral director Dumcau

(b) Address M+View 720

19. (a) 11-15-41 (b) Frank Boyd M: 8  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon <sup>101</sup>

(c) City or town Quincy, Mo <sup>0</sup>  
(If outside city or town limits, write "RURAL")

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

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 15  
year 41 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify, that I attended the deceased from 11/10/41  
19 \_\_\_\_\_ to 11/15/41 19 \_\_\_\_\_

that I last saw her alive on 11/15/41 19 41

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

Immediate cause of death Myo carditis <sup>Dr. Boyd</sup>

Due to \_\_\_\_\_

Due to 1470

Other conditions Tremorancy & no tumor  
(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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. T. Eudy (M. D. or other) \_\_\_\_\_

Address Quincy Date signed 11-18-41

Dr. Boyd

Dr. Eudy  
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. 5,

District File Number 12412084

Date Filed .....

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**