

FILED APR 9 1942

Registration District No. **806**

Primary Registration District No. **4485**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Queen City MO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None  
(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 MERRY E. Jarr

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Jarr 6. (c) Age of husband or wife if alive Deceased years \_\_\_\_\_ (Month) (Day) (Year)

7. Birth date of deceased Oct 14 1846

8. AGE: Years 96 Months 4 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Work

11. Industry or business Same

MOTHER FATHER { 12. Name Leona Powers 9

{ 13. Birthplace Not Known 9 (City, town, or county) (State or foreign country)

{ 14. Maiden name Mariah York 9

{ 15. Birthplace Not Known 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Yvonne Brower

(b) Address Queen City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-26-1942 (Month) (Day) (Year)

(c) Place: burial or cremation Queen City, Regentary

18. (a) Signature of funeral director Wm H Webb

(b) Address Queen City MO

19. (a) Feb. 24 42 (Date received local registrar) (b) Oliver B Jones-dep (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24 year 1942 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1-21-42 to 2-24-42 and that I last saw her alive on 2-24-42 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

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

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

Other conditions (Include pregnancy within 3 months of death) 1316

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 CA Way Dodel, D.O. (M. D. or other)

Address Greentop, Mo. Date signed 2-24-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 Self

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

Wm N West

Licensed Embalmer No.

2882

P. O. Address

Quincy 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.**