

Registration District No. 73

Primary Registration District No. 5290

Registrar's No. 42

1. PLACE OF DEATH: CLAY

(a) County KEARNEY, MO. R.F.D.

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

(c) Name of hospital or institution: HOME Kearney, Mo.  
(If not in hospital or institution, write street number or location)

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

In this community LIFETIME years, months or days

2. USUAL RESIDENCE OF DECEASED: 24

(a) State MO. (b) County CLAY 0

(c) City or town KEARNEY, MO. R.F.D. 0  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? NO (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BETTIE MAE MAGEE

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 FRANK MAGEE 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased JUNE 26 1882  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR. day 7  
year 1943 hour 1:15 minute \_\_\_\_\_ p. A. M.

21. I hereby certify that I attended the deceased from 4-5-1943 to 4-7-1943  
that I last saw h.f.r. alive on 4-7-1943  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

60 9 12 hr. \_\_\_\_\_ min.

Immediate cause of death Diabetes Mellitus

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

Due to 61

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace CLAY COUNTY MO. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

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

MOTHER FATHER { 12. Name JOHN AKER

{ 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 9

{ 14. Maiden name KATHERINE SHAFER

{ 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 9

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant FRANK MAGEE

(b) Address KEARNEY, MO. R.F.D.

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? \_\_\_\_\_

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4 9 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation SMITHVILLE, MO

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

Means of injury \_\_\_\_\_

18. (a) Signature of funeral director McQuinn Funeral Home

(b) Address Smithville, Mo.

23. Signature [Signature] (M. D. or other) MA

(c) Address \_\_\_\_\_

19. (a) June 12 1943 (b) [Signature] (Date received local registrar) (Registrar's signature)

Address Smithville Date signed 4-9-43

June 3, 1943 (Licensed Emballer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 7-13-43

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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..... S. A. McComas.....

Licensed Embalmer No. 2303.....

P. O. Address..... Smithville, 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.**