

FILED SEP 10 1943

State File No. _____

Registration District No. _____

Primary Registration District No. 4068

Registrar's No. 266

1. PLACE OF DEATH:

(a) County CALLAWAY

(b) City or town MOKANE
(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 LIFE years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY

(c) City or town MOKANE
(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 _____

3. (a) PRINT FULL NAME MARY Level

3. (b) If veteran, name war NO

3. (c) Social Security No. NO. N. O. N. R.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18 year 1943 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from 3/10 1942 to 8/18 1943 that I last saw her alive on 8/18 1943 and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race White

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife John Robert Level

6. (c) Age of husband or wife if alive DECEASED years

7. Birth date of deceased July 27 1860
(Month) (Day) (Year)

Immediate cause of death Uterine Carcinoma

Due to _____

Due to _____

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

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>0</u>	<u>22</u>	hr. _____ min.

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

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name NICHOLAS BREID

{ 13. Birthplace GERMANY
(City, town, or county) (State or foreign country)

{ 14. Maiden name SUSAN CHECK

{ 15. Birthplace PENNA
(City, town, or county) (State or foreign country)

16. (a) Informant MRS J. K. PIERCE

(b) Address MOKANE, MO

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

(c) Place: burial or cremation MOKANE

18. (a) Signature of funeral director Glen G. Manspin

(b) Address 712 Court St. Fulton, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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. D. Payne (M. D. or other) _____

Address R. H. L. Fulton Date signed 8-19-43

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

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..... *Glen Y. Maupin*.....
Licensed Embalmer No. *2725*.....
P. O. Address..... *Fulton, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 266

EP 10-19

Registration District No. 47

Primary Registration District No. 4068

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Mechanick
(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 Mary Jewel

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

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

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

7. Birth date of deceased July 27 1886
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 8-20-1943 (b) Joie Morsinkhoff
(Date received local certifier) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August 1943 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 1943 _____
that I last saw him alive on _____ 1943 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

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? _____ (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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

FILED

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