S. No. 2
M—9-4-41
5-17-39
PI X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30942

Registration District No. 149 — Primary Registration District No. 1002 — Registrar's No. 4133

1. PLACE OF DEATH:

(a) County: Jackson
(b) City or town: K.C. Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3241 Wabash, K.C. Mo. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 week (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson 48
(c) City or town: Independence (If outside city or town limits, write "RURAL")
(d) Street No.: 810 W. Waldo 4 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 1

3. (a) PRINT FULL NAME: ANNA MARY SAVILLE

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Jan (Month) 24 (Day) 1849 (Year)

8. AGE: Years: 94 yrs; Months: 8; Days: 3; If less than one day: hr. min.

9. Birthplace: Wayne County (City, town, or county) Ohio (State or foreign country) 1

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: James Galloway 1
13. Birthplace: Ohio (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Susanna Neff 1
15. Birthplace: Ohio (City, town, or county) (State or foreign country)

16. (a) Informant: Kathryn M. Piper
(b) Address: 810 W. Waldo.

17. (a) Mound Grove (Burial, cremation, or removal) (b) Date thereof: 9/29-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Mound Grove Cemetery

18. (a) Signature of funeral director: Conley Funeral Home
(b) Address: Independence, Missouri

19. (a) 9-29-43 (Date received local registrar) (b) J. E. Brown, Dep (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day: 27 year: 1943 hour: 11 minute: 30 P.M.

21. I hereby certify that I attended the deceased from: For several years, 19 to 19 43 that I last saw h. alive on: Sept 27 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death: Senility Exhaustion

Due to: Bedridden by fracture of the hip

Due to: Jan 1940 to 1943

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

Major findings:
Of operations: 1620

Of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature: Johnson Crayne (M.D. or other)
Address: Independence, Mo. Date signed: 9-28-43

(Licensed Embalmer's Statement on Reverse Side)

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address Indep. 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.