

FILED JAN 11 1944
Registration District No. **195**

Primary Registration District No. **5714**

Registrar's No. **35**

1. PLACE OF DEATH:

(a) County **McDonna**
(b) City or town **Rural Whitereck TWP.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
12 Miles East Of Pineville 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.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **McDonna**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Anderson MO. R. # 3**
(If rural, give location)
(e) Citizen of foreign country? **NO.** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **MARPHA MAY, REARRICK**

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 **Single**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Dec., 6th, 1889**
(Month) (Day) (Year)

8. AGE: Years **54** Months **0** Days **6** If less than one day hr. min.

9. Birthplace **Jasper County MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business.....

MOTHER FATHER
12. Name **Jacob Rearrick**
13. Birthplace **IOWA**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Miller**
15. Birthplace **South Carolina**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henry Rearrick**

(b) Address **Anderson MO R. # 3**

17. (a) **Burial** (b) Date thereof **Dec. 13th, 1943**
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation **Tracy Cemetery**

18. (a) Signature of funeral director **Charles Williams**

(b) Address **St. Louis MO**

19. (a) **1-5-1944** (b) **Jona Martin**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **12th.**
year **1943** hour **11** minute **10, P.** M.

21. I hereby certify that I attended the deceased from **Dec. 11**
1943 to **Dec. 12** 1943;
that I last saw h. e. c. alive on **Dec. 11** 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death **acute myocardial degeneration** Duration

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) (c) Means of injury

23. Signature **R. P. Roberts** (M. D. or other) **do**

Address **Pineville** Date signed **Dec. 13, 1943**

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

1205

RECEIVED

District Health Officer No. 61

District File Number 148-35

Date Filed 1-10-44

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, fact should be so stated above.