

FILED JAN 10 1944

Registration District No. **274**

Primary Registration District No. **5934**

1. PLACE OF DEATH:

(a) County **PELLTIS**  
(b) City or town **RURAL SEDALIA Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**RFD #11.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **20 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **PELLTIS**  
(c) City or town **RURAL**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **RFD #11, SEDALIA.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **ELIZABET K. M'CBABE**

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

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

6. (b) Name of husband or wife **W.H. M'CBABE** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **4 3 1852**  
(Month) (Day) (Year)

8. AGE: Years **91** Months **8** Days **20** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **ASHLEY Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name **LAWSON V. LAFFERTY**

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

14. Maiden name **HESTER ANN** (State or foreign country)

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

16. (a) Informant **MRS. CHAS. RICHEY**  
(b) Address **SEDALIA-RFD #11.**

17. (a) **BURIAL** (b) Date thereof **12/27/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Home Hill Sedalia, Mo**

18. (a) Signature of funeral director **[Signature]**  
(b) Address **Sedalia, Mo**

19. (a) **11/27/43** (b) **Mrs Anna Burger**  
(Date received final registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **23** year **1943** hour **8** minute **P** M.

21. I hereby certify that I attended the deceased from **Lawson** **James** in last **4** months, or that I last saw him or her alive on **Dec 23, P.M.** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac respiratory failure** Duration \_\_\_\_\_

Due to **Senility**

Due to **167**

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

Major findings: **No operation**

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

Of autopsy **No autopsy**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No.**

(b) Date of occurrence **None**

(c) Where did injury occur? **No injury**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **No**

While at work? **No** (Specify type of place or means of injury)  
23. Signature **B. B. Mader** (M. D.)  
Address **Sedalia, Mo** Date signed **12/27/43**

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-7-48

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. 2867

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.