

FILED JAN 12 1944

Registration District No. **3072**

Primary Registration District No. **3072**

Registrar's No. **240**

1. PLACE OF DEATH:

(a) County **Saline**
(b) City or town **Marshall**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
457 South Lyon
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **55 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline**
(c) City or town **Marshall**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. **457 South Lyon**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ellie May Merry**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** / race **White** / 5. Color or race _____ 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Edwin H. Merry** 6. (c) Age of husband or wife if alive **84** years

7. Birth date of deceased **May 1st, 1863**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	7	29	hr. _____ min.

9. Birthplace **Logansport Ind.**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

12. Name **John Z. Smith**

13. Birthplace **Greensburg Ohio.**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Elizabeth Rinehart**

15. Birthplace **West Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Ray Eubank**
(b) Address **Slater, Mo.**

17. (a) **Burial** (b) Date thereof **Jan. 2, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ridge Park Cemetery**

18. (a) Signature of funeral director **Amber-Russ**
(b) Address **Marshall, Mo.**

19. (a) **1-4-1944** (b) **Mrs. S. O. Westbrook**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **30**
year **1943** hour **4** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Dec 15** 19**43** to **Dec 30** 19**43** that I last saw her alive on **Dec 30** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Myocarditis**
Due to _____

Due to _____
Other conditions (Include pregnancy within 3 months of death) **Influenza**

Major findings: Of operations **930**
Of autopsy _____

Duration **1 yr**
PHYSICIAN **10 days**
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?

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

23. Signature **[Signature]** (M. D. or other) _____
Address **[Address]** Date signed **1/3/44**

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

MOTHER FATHER

12/5

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

1-10-44

V.S. No. 2
1000-2-20

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 _____

R. W. Campbell

Licensed Embalmer No. _____

3469

P. O. Address _____

Marshall

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.