

FILED MAR 8 1944
1948

Registration District No. **198**

Primary Registration District No. **4310**

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Bevier
(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 Month _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Bevier
(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 Blanch Baxter

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

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

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

7. Birth date of deceased: Jan 12 (Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation at Home

11. Industry or business _____

12. Name Theodore Sargent

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Opie Hayes

(b) Address Brookfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Harwood Mo

18. (a) Signature of funeral director Wm J. Rowland

(b) Address Brookfield Mo

19. (a) 2-5-44 (Date received local registrar) (b) Wm J. Rowland (Registrar's signature)

10289

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day Feb
year 1944 hour 5 Pm minute _____ p.m.

21. I hereby certify that I attended the deceased from Feb 4, 1944 to Feb 5, 1944
that I last saw her alive on Feb 5, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy (Cerebral) Duration 2 days

Due to Arteriosclerosis

Due to _____

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations 930

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Dr. E. R. Woodhead
Address Bevier, Mo Date signed 2/5/44

RECEIVED

District Health Officer No. 10

District File Number 3-44-492

Date Filed MAR 7 1944

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..... *Homey Bowden*

Licensed Embalmer No. 3295

P. O. Address..... *Homey Bowden*

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.