

3-2
5-43
5-17-39
X38671

FILED MAR 9 1944
Registration District No. 3394

Primary Registration District No. 6198

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

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Rural Cass. Imp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 43 yrs. (Specify whether years, months or days)

In this community 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas ¹⁰⁷

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Cass. Imp. Elk Creek mo.
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME NANCY ELEANOR MARESS

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

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

6. (b) Name of husband or wife Rew 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Aug 18 1884
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 0 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name James Dillen ⁹

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

14. Maiden name 9

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

16. (a) Informant Rew Mareess

(b) Address Elk Creek mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Steeley Chapel Elk Creek mo.

18. (a) Signature of funeral director Gaylord B. Elliott
(b) Address Cabool mo.

19. (a) Feb 19-1944 (Date received local registrar) (b) ma Lou Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 1944 year 10 hour 30 minute am M.

21. I hereby certify that I attended the deceased from Feb 18 1944 to Feb 18 1944
that I last saw her alive on Feb 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage ^{Duration 3 hours}

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 93 a

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature L. E. Edens (M. D. of other) _____
Address Cabool mo. Date signed Feb 19

1239

44

RECEIVED

District Health Officer No. 5
District File Number 344192
Date Filed 3-8-44

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 Taylor V. Ellett
Licensed Embalmer No. 2252

P. O. Address Cabool 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 359

Primary Registration District No. 6198

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Camp
(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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 18
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days _____ If less than one day _____ min.
9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name James Allen
13. Birthplace Excelsior Springs Mo
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Clemons
15. Birthplace Platte Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) Mrs Lon Miller
(Date received local registrar) (Registrar's signature)

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?

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

8573