

FILED JUN 23 1944

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 97

1. PLACE OF DEATH  
 (a) County Cass  
 (b) City or town Harrisonville  
 (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) 1  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community 5 years  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Cass  
 (c) City or town Harrisonville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 900 S. Independence  
 (If rural, give location)  
 (e) Citizen of foreign country?  (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME Mary Ida Blary  
 3. (b) If veteran,  name war \_\_\_\_\_  
 3. (c) Social Security No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month June day 12<sup>th</sup>  
 year 1944 hour 9 minute 30P M.  
 21. I hereby certify that I attended the deceased from June 9, 1944, to July 12, 1944  
 that I last saw her alive on June 11, 1944  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Clavel Franklin Blary  
 6. (c) Age of husband or wife if alive 4 years  
 7. Birth date of deceased: March 9 1858  
 (Month) (Day) (Year)

Immediate cause of death Uræmic Coma  
 Duration \_\_\_\_\_

8. AGE: Years 86 Months 3 Days 3  
 If less than one day \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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

10. Usual occupation Attorney  
 11. Industry or business Home maker  
 12. Name Joseph Anate  
 13. Birthplace \_\_\_\_\_  
 14. Maiden name Martha Johnson  
 15. Birthplace \_\_\_\_\_

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 ADDITIONAL ELEMENTARY INFORMATION REQUESTED

16. (a) Informant Mrs. Emma E. Bernal  
 (b) Address Harrisonville Mo  
 17. (a) Burial (b) Date thereof 6/14/44  
 (Burial, cremation, or other) (Month) (Day) (Year)  
 (c) Place: burial or cremation Pleasant Valley

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? \_\_\_\_\_

18. (a) Signature of funeral director RUNNENBURGER'S  
 (b) Address HARRISONVILLE, MO  
 19. (a) June 16 1944 (b) Margaret Tolle  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature W. Scott (M. D. or other) \_\_\_\_\_  
 Address Harrisonville Mo Date signed Jun 13

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

MOTHER FATHER

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

*Ernest R. Remmenburger*

Licensed Embalmer No.

*3368*

P. O. Address

*Harrisonville 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. *11*

Registration District No. *59*

Primary Registration District No. *4027*

Registrar's No. *1*

1. PLACE OF DEATH:

(a) County *Cass*

(b) City or town *Harrisonville*  
(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 *Mary Ida Clary*

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* year *1946* at \_\_\_\_\_ M. *8* minute \_\_\_\_\_

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 \_\_\_\_\_

4. Sex *F*

5. Color or race *W*

6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *March 9*  
(Month) (Day) (Year)

Duration \_\_\_\_\_

*Uraemic Coma  
with Chronic Nephritis*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

8. AGE: Years *86* Months *2* Days *22* If less than one day \_\_\_\_\_ min.

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(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) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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) (Means of injury)

23. Signature *J. M. Seal* (M. D. or other) \_\_\_\_\_  
Address *Harrisonville Mo* Date signed *1 Jun 26 1946*

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

SUPPLEMENTARY

21301