

FILED JUL 13 1944

Registration District No. 227

Primary Registration District No. 3048

Registrar's No. 101

1. PLACE OF DEATH:  
 (a) County Madaway  
 (b) City or town Manlyville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Francis  
(If not in hospital or institution, write street number or location) 0  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days) 30 days about

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Worth 1130  
 (c) City or town Grant City 0  
(If outside city or town limits, write "RURAL")  
 (d) Street No. # "Rural" S-W  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joan Grant Roach  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 496-05-8318

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month June day 24  
 year 1944 hour 12:20 minute 14 M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife Martha Mae Holmes 6. (c) Age of husband or wife if alive 17 years  
 7. Birth date of deceased Jan 30 1912  
(Month) (Day) (Year)

Immediate cause of death strychnine sulphate poisoning Duration 3 hours  
 Due to (Saban by mouth)

8. AGE: Years 32 Months 4 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions 163 E  
(Include pregnancy within 3 months of death)  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy Cerebral Inquest

9. Birthplace Mound City Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Laborer  
 11. Industry or business \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Suicide  
 (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 \_\_\_\_\_

MOTHER FATHER  
 12. Name Grant Roach  
 13. Birthplace Halt Co Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Flossie Hard  
 15. Birthplace Henry Co Missouri  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Martha Mae Roach  
 (b) Address 211 South Water Manlyville Mo  
 17. (a) Burial (b) Date thereof 6-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Gravestone Oak Mo  
 18. (a) Signature of funeral director Camrball Federal Dodge  
 (b) Address 951 South Main Manlyville Mo  
 19. (a) 6-27-44 (b) Amy Garber  
(Date received local registrar) (Registrar's signature)

23. Signature W.P. Fahrner (M. D. or other) \_\_\_\_\_  
 Address Manlyville, Mo Date signed 6-24-44

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

1349

**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..... *William Campbell*  
Licensed Embalmer No..... *2620*  
P. O. Address..... *Marionville 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.**