

FILED SEP 7 1944
Registration District No. **264**

Primary Registration District No. **5894**

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

1. PLACE OF DEATH:
(a) County Ozark
(b) City or town Rural- Pine Creek
(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 70 years (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ozark
(c) City or town Gainesville Rural
(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 NAME Mary Elcaney Mayberry
FULL NAME
3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife J.P. Mayberry 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 17 1862
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 22
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Logan H. Loftis
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Melinda Loftis
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Neal Mayberry
(b) Address Thornfield St Mo.

17. (a) Burial (Burial, cremation, or removal) Date thereof 8-10-44
(Month) (Day) (Year)
(c) Place: burial or cremation Loftis Cemetery

18. (a) Signature of funeral director Clinkingbeard Fun. Home
(b) Address Gainesville, Missouri

19. (a) 8-13-44 (Date received local registrar) (b) Margaret Hutchins (Registrar's signature)

MEDICAL CERTIFICATION
20. **DATE OF DEATH:** Month August day 9
year 1944 hour 5 minute 30 A. 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.

Immediate cause of death Cerebral Hemorrhage
Duration 2 weeks

Due to 8391

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____
Signature C.A. Beach M.D. (M.D. or other)
Address Cajon Mo. Date signed 8-13

RECEIVED

District Health Officer No. 6;

District File Number 944-976

Date Filed SEP 5 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 W B Dutchman

Licensed Embalmer No. 3431

P. O. Address Gainesville Va

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.