

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town Rural Spring City
(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 1 (Specify whether)
In this community 3 years years, months or days

3. (a) PRINT FULL NAME Anna Mary Fox
(b) If veteran, name war
(c) Social Security No.

4. Sex Female
5. Color or race W
6. (a) Single, widowed, married divorced
(b) Name of husband or wife Ed. Fox
6. (c) Age of husband or wife if alive 1883 years
7. Birth date of deceased Feb. 4 1883 (Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

MOTHER FATHER
11. Industry or business
12. Name Silas Stogsdal
13. Birthplace Ky. (City, town, or county) (State or foreign country)
14. Maiden name Olga Stern
15. Birthplace Mo. (City, town or county) (State or foreign country)

16. (a) Informant Ed. Fox
(b) Address Edgewood Springs Star Route, Rella Mo

17. (a) Burial, cremation, or removal
(b) Date thereof 9-3-44 (Month) (Day) (Year)
(c) Place: burial or cremation Silas Knob hem

18. (a) Signature of funeral director Rella Mo
(b) Address

19. (a) 9-2-44 (b) (Registrar's signature) Address Rella Mo Date signed 9-1-44 (If received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Phelps
(c) City or town Edgewood Springs Star Route (If outside city or town limits, write "RURAL")
(d) Street No. Rella Mo (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 1 year 1944 hour 6 minute a M.
21. I hereby certify that I attended the deceased from May 1, 1944, to Sept 1, 1944, and that death occurred on the date and hour stated above.
Immediate cause of death Brain Tumor (Type unknown) 6 mo. Duration

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations Snd
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
23. Signature E. E. Feind M.D. (M. D. or other) Address Rella Mo Date signed 9-1-44

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

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 _____

Licensed Embalmer No. 3397

P. O. Address. Rolla 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.