

FILED OCT 20 1944

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 230

1. PLACE OF DEATH: **BOONE**

(a) County **BOONE**

(b) City or town **COLUMBIA**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution **LOFE** / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **BOONE**

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

(d) Street No. **1608 BASS AVE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **XX**

3. (a) PRINT FULL NAME **MARY ELIZABETH CROSS KETCHUM**

3. (b) If veteran, name war **XX**

3. (c) Social Security No. **XXX**

4. Sex **FEMALE** / 5. Color or race **WHITE**

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

6. (b) Name of husband or wife **GEORGE W. KETCHUM**

6. (c) Age of husband or wife if alive **1868** years

7. Birth date of deceased: **Dec** / **29** / **1868**
(Month) (Day) (Year)

8. AGE: Years **75** Months **8** Days **16** If less than one day hr. min.

9. Birthplace **BOONE CO MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

12. Name **SAMUEL FRANKLIN CROSS**

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

14. Maiden name **SUSAN FRANCIS ADAMS**

15. Birthplace **BOONE CO MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS M. D. JETT**

(b) Address **COLUMBIA Missouri**

17. (a) **Burial** (b) Date thereof **9/17/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MEMORIAL PARK CEM**

18. (a) Signature of funeral director **R. D. Willett**

(b) Address **COLUMBIA MO**

19. (a) **9-15-44** (b) **Edna H. Barber**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT** day **15th**
year **1944** hour **1:40** minute **A.** M.

21. I hereby certify that I attended the deceased from **July** 1944 to **Sept 15** 1944
that I last saw **her** alive on **Sept 15** 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Arteriosclerosis**

Due to **Myocardial Infarction**

Due to **Myocardial Infarction**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **94a**

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 **R. D. Willett** (M. D. or other) **MD**

Address **Columbia** Date signed **9/15/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1250

RECEIVED.

District Health Officer No. 9,

District File Number.....

Date Filed 10-18-44

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: *[Handwritten Signature]*

Licensed Embalmer No. 3183

P. O. Address: *[Handwritten Address]*

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.