

FILED JAN 17 1945

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **243**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Fisherville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home #4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community **2 months 12 days.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shelby 102**
(c) City or town **Shelbyville**
(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 FULL NAME

EVA MAHAFFEY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife **Philip Pulsey** 6. (c) Age of husband or wife if alive **47** years
7. Birth date of deceased **Oct 21 1897**
(Month) (Day) (Year)

8. AGE: Years **67** Months **2** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **Mt. Vernon Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Sec. Security - Corman**

(b) Address **Burial**

17. (a) **Burial** (b) Date thereof **12-30-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **100th Cemetery Shelbyville Mo**

18. (a) Signature of funeral director **E.P. Thompson**

(b) Address **Shelbyville Mo**

19. (a) **12-29-44** (b) **Mrs. J. Wagner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27**
year **1944** hour _____ minute **10** M.

21. I hereby certify that I attended the deceased from **May 5**, 1944, to **Dec 27**, 1944.
that I last saw **her** alive on **Dec 27**, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death **auricular fibrillation** Duration **7 days**
Due to **hypertensive heart disease** ?

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
93d

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? _____

(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature **MT. Gutenschn** (or other) **Dr.**

Address **Kirksville, Mo** Date signed **12-27-44**

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 1-45-86
Date Filed JAN 9 1945

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 E. P. Thompson
Licensed Embalmer No. 1632
P. O. Address Shelbyville, 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.