

FILED JAN 15 1945

Registration District No. 5-2-6-6-8

Primary Registration District No. 2-8-4-1-9

Registrar's No. 34

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

2200

1. PLACE OF DEATH:

(a) County Christian Mo  
(b) City or town Ozark Mo  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 year or more years, months or days

3. (a) PRINT FULL NAME

Martha Foote

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 3

5. Color or race Colored

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Home Keeper

11. Industry or business

MOTHER FATHER

12. Name Sarah Weaver

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

14. Maiden name Adont know

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

16. (a) Informant Byron Kelley

(b) Address Ozark Mo.

17. (a) Burial (b) Date thereof Jan 1-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Weaver Cemetery

18. (a) Signature of funeral director T. B. Chubb  
(b) Address Ozark Mo.

19. (a) 1-2-45 (b) Mabel Mapes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian  
(c) City or town Ozark Mo. Ill  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25  
year 1944 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 5 1944 to Dec 29 1944  
that I last saw him alive on Dec 29 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis Soft side Body  
Due to hemorrhage of Brain

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 730  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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 J. H. Hade (M. D. or other) \_\_\_\_\_  
Address Ozark Mo. Date signed 1-1-45

1361

RECEIVED

District Health Officer No. 6,  
District File Number 143-SS

Date Filed JAN 12 1945

SEP 27 1946

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

T. B. Chaffin

Licensed Embalmer No.

2192

P. O. Address

Ozark, 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.