

No. 2
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-17-39
X37823

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

FILED JAN 4 1945

Registration District No. **67**

Primary Registration District No. **6266**

Registrar's No. **78**

1. PLACE OF DEATH:

(a) County Christian

(b) City or town Sparta Mo. RR
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: none in hospital or institution. (Specify whether)

In this community most of Her Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian

(c) City or town Sparta Mo. RR 22
(If outside city or town limits, write "RURAL")

(d) Street No. Sparta Township
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME Anne Mae Inman

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

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Aug 3 1924
(Month) (Day) (Year)

8. AGE: Years 20 Months 3 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation House work

11. Industry or business _____

MOTHER FATHER { 12. Name Irish J. Inman

13. Birthplace Green Mo. U
(City, town, or county) (State or foreign country)

14. Maiden name Martha Jane Hale

15. Birthplace Christian Mo. U
(City, town, or county) (State or foreign country)

16. (a) Informant I. J. Inman

(b) Address Sparta Mo. RR

17. (a) Buried (b) Date thereof Nov. 24 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sparta Cemetery

18. (a) Signature of funeral director T. B. Chubb

(b) Address Osark Mo

19. (a) 12-29-1944 (b) Wm S. M. Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22
year 1944 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct. 24 - 1944 to Nov - 22 - 1944
that I last saw her alive on Nov - 14 - 1944
and that death occurred on the date and hour stated above.

Immediate cause of death collapse + shock

Due to Malnutrition Duration 6 mo

Due to _____

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

Major findings:
Of operations _____ **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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)

(c) Means of injury no. 11

23. Signature Harrold K. Nelson (M. D. or other) 4460

Address Sparta, Mo Date signed 11-25-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 2182

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.

JAN 5 1944

Registration District No. 67

Primary Registration District No. 5265

78

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

1. PLACE OF DEATH: Christian
 (a) County _____
 (b) City or town Rural Spruce Map
(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 _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Anna M. Inman
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 20 Months 3 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 2
 Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
 that last saw him _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____

Due to self starvation
from fear of gaining weight.
 Due to _____ 189

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

ADDITIONAL
 SUPPLEMENTARY
 INFORMATION
 REQUESTED

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) No external cause

(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? Died in her home

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

FILED

40879