

FILED FEB 10 1945

Registration District No. 18

Primary Registration District No. 5359

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town "Rural" Grand River Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
6 Miles N. E. Jameson, Missouri  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community Most of Life  
years, months or days)

8. (a) PRINT FULL NAME Artimissa Margaret Tibbles

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Albert B. Tibbles 6. (c) Age of husband or wife if alive Dec'd years  
7. Birth date of deceased March 16 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>10</u>	<u>4</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER  
12. Name John Railsback  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Lucinda Carter  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Walter Tibbles  
(b) Address Jamesport, Missouri  
17. (a) Burial (b) Date thereof 1-22-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Grand River Cemetery

18. (a) Signature of funeral director Hope Funeral Home  
(b) Address Gallatin, Missouri  
19. (a) 1-24-1945 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess  
(c) City or town Rural Grand River, Twp.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6 Miles N. E. Jameson, Mo.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 20  
year 1945 hour \_\_\_\_\_ minute P/ M.

21. I hereby certify that I attended the deceased from Jan 15  
1945, to Jan 15, 1945  
that I last saw her alive on Jan 15, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Nonseptical (left side)  
Due to arteriosclerosis  
Due to rapportis

Other conditions (Include pregnancy within 3 months preceding death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 \_\_\_\_\_  
28. Signature M. B. Bailey (M.D. or other)  
Address Pellatte, Mo. Date signed 1/24/45

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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

*L. A. Richardson*

Licensed Embalmer No. *3301*

P. O. Address

*Salisbury, 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, above space should be left blank.**

State File No. March  
Registrar's No. 3

Registration District No. 98 Primary Registration District No. 5359

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Rural Grand River  
(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 Artemissa M. Finkle

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 W

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

7. Birth date of deceased March 16  
(Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) MO

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 \_\_\_\_\_  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to nephritis Chronic

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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 M. P. Bailey (M.D. or other) \_\_\_\_\_  
Address Palletta 240 Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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