

**FILED APR 9 1945**

Registration District No. **323**

Primary Registration District No. **6090**

Registrar's No. **35**

**1. PLACE OF DEATH:**

(a) County **SALINE**  
(b) City or town **RURAL, LIBERTY TWP**  
(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 **LIFE**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MO** (b) County **SALINE 07**  
(c) City or town **SWEET SPRINGS RURAL**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **LIBERTY TWP**  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **LUCY ANN MAYSE**

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 **WIDOWED**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **JAN 20 1856**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**95 1 17** hr. min.

9. Birthplace **SALINE CO MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **DR. REAVIS**  
13. Birthplace **NOT KNOWN TENN**  
(City, town, or county) (State or foreign country)  
14. Maiden name **SARAH CAREY**  
15. Birthplace **NOT KNOWN IND**  
(City, town, or county) (State or foreign country)

16. (a) Informant **ARTHUR MAYSE**

(b) Address **SWEET SPRINGS MO**

17. (a) **BURIAL** (b) Date thereof **3-8-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ANTIOCH**

18. (a) Signature of funeral director **R.C. Carter**

(b) Address **Summit Grove Mo**

19. (a) **March 9-45** (b) **Ms. E. S. Mueller, dep.**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **March** day **7<sup>th</sup>**  
year **1945** hour **8:30** minute **A.M.**  
21. I hereby certify that I attended the deceased from **1940**  
\_\_\_\_\_, 19\_\_\_\_, to **March 7**, 19**45**  
that I last saw her alive on **March 7**, 19**45**;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Pneumonia due fall** ✓  
**Pneumonia due fall** ✓

Duration

**1 wk**

Due to \_\_\_\_\_  
Due to **Senility** **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 **Chas R Parsons** (M. D. or other) **me**  
Address **Sweet Springs Mo** Date signed **3/8/45**

1218

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

RECEIVED

District Health Officer No. B.

District File Number

Date Filed 4/8/15

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..... *R. C. Carter*

Licensed Embalmer No. 13613

P. O. Address *S. H. [unclear]*

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.

2B  
33  
36930

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 34

Registration District No. 323 Primary Registration District No. 6090

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Rural Liberty Twp  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Lucy Ann Mays  
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 Jan 20 1898  
(Month) (Day) (Year)

8. AGE: Years 95 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Mo  
(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 Mar Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
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) Accident  
(b) Date of occurrence Feb 27, 1945  
(c) Where did injury occur? Sweet Springs, Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home  
While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature Cha R Parsons (M. D. or other) MD  
Address Sweet Springs Date signed 4/12/45

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

SUPPLEMENTARY

10747