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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 8 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13684

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 87

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
McCune-Brooks Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1½ days (Specify whether
In this community 59 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Carthage 1
(If outside city or town limits, write "RURAL") 3

(d) Street No. 207 W. 7th. St.
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country - - -

3. (a) PRINT FULL NAME Mary Means

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife J. W. Means

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

7. Birth date of deceased January (Month) 10 (Day) 1862 (Year)

8. AGE: Years 83 Months 3 Days 4 If less than one day hr. min.

9. Birthplace Moorsville (City, town, or county) Indiana 1 (State or foreign country)

10. Usual occupation At Home

11. Industry or business None

FATHER
12. Name W. F. Bray
13. Birthplace Unknown (City, town, or county) Indiana 1 (State or foreign country)

MOTHER
14. Maiden name Anna H. Harvey
15. Birthplace Moorsville (City, town, or county) Indiana 1 (State or foreign country)

16. (a) Informant Mrs. Rosetta Holbrook
(b) Address 815 S. Garrison, Carthage, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 16, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri

19. (a) April 16 '45 (Date received local registrar) (b) Elizabeth Couplin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1945 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from Dec 2, 1942 to April 13, 1945
that I last saw her alive on April 13, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	? yrs.
Due to Chronic Rheumatoid Arthritis	? yrs.
Other conditions Chronic Myocarditis (Include pregnancy within 3 months of death)	? yrs.

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

23. Signature [signature] (M. D. or other) M.D.
Address Carthage Date signed 4-16-45

1203

(Licensed Embalmer's Statement on Reverse Side)

45-4-324

MAY 8 1945

MAY 4 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 Emm L Stuart

Licensed Embalmer No. 391

P. O. Address Carthage

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.