

FILED MAY 11 1945  
Registration District No. 201

Primary Registration District No. 4319

Registrar's No. 41

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

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Belle Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether years, months or days)  
In this community 1  
years, months or days

3. (a) PRINT FULL NAME

Rose Emeline Abel

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 Married

6. (b) Name of husband or wife Geo. N. Abel

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased (Month) Feb

(Day) 21

(Year) 1880

8. AGE:

Years

Months

Days

If less than one day

65

1

16

hr.

min.

9. Birthplace

Desota  
(City, town, or county)

Mo.  
(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Martin Wilson

13. Birthplace

Desota  
(City, town, or county)

Mo.  
(State or foreign country)

14. Maiden name

Unknown

15. Birthplace

—  
(City, town, or county)

—  
(State or foreign country)

16. (a) Informant

Mr Geo. Abel

(b) Address

Belle Mo.

17. (a)

Burial  
(Burial, cremation, or removal)

(b) Date thereof

4-9-45  
(Month) (Day) (Year)

(c) Place: burial or cremation

Liberty Cemetery

18. (a) Signature of funeral director

Clayton M. Mott

(b) Address

—

19. (a)

4/21/45  
(Date received local registrar)

(b)

Erma Bassett  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Osage 76  
(c) City or town Belle Mo. 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. — 0  
(If rural, give location)  
(e) Citizen of foreign country? No 0 (Yes or No)  
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 7  
year 1945 hour 8 minute 30 M.

21. I hereby certify that I attended the deceased from MAY 45  
1 1943 to 4-7 1945  
that I last saw her alive on 4-1 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death.

Exophthalmic goiter

Due to

Due to

Other conditions

Gastritis  
(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) No  
(b) Date of occurrence —  
(c) Where did injury occur? No  
(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 Bl Bunge (M. D. or other)  
Address Blair St Mo Date signed 4-9-45

1096

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 5-10-45

MAY 19 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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**