

Registration District No. **133**

Primary Registration District No. **3022**

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

1. PLACE OF DEATH:
 (a) County **Harrison**
 (b) City or town **Bethany**
 (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 **50 years** years, months or days

3. (a) PRINT FULL NAME **Anna H. Magee**
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: **James Magee deceased** **6. (c) Age of husband or wife if** **alive** years
7. Birth date of deceased: **Oct 26 1864** (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	6	12	hr. min.

9. Birthplace: **7 Jersey County Kentucky** (City, town, or county) (State or foreign country)

10. Usual occupation: **7 Farmer**

11. Industry or business: _____

12. Name: **Don't Know**
13. Birthplace: **Don't Know** (City, town, or county) (State or foreign country)
14. Maiden name: **Don't Know**
15. Birthplace: **Don't Know** (City, town, or county) (State or foreign country)

16. (a) Informant: **Arthur Magee**
(b) Address: **Bethany Mo**

17. (a) Burial, cremation, or removal: **Rural** **(b) Date thereof:** **May 10 1945** (Month) (Day) (Year)
(c) Place: burial or cremation: **Mason Cemetery**

18. (a) Signature of funeral director: **Joe E. Wheeler**
(b) Address: **Bethany Mo**

19. (a) May 10 - 1945 **(b) Zola M. Burris** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Harrison**
 (c) City or town **Bethany** **41** (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) _____
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **8** year **1945** hour **7** minute **P** M.

21. I hereby certify that I attended the deceased from **May 10 1945** to **May 8 1945**
 that I last saw him alive on **May 7 1945**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Apoplexy**
 Due to _____
 Due to _____

Other conditions: _____
 (Include pregnancy within 3 months of death)
 Major findings: **(b) (c) (d)**
 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? _____

23. Signature: **Amos L. Wood** **(M. D. or other)**
Address: **Bethany Mo** **Date signed:** _____
 While at work? _____ (Specify type of place)
 (e) Means of injury: **2**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 Joe E. Wheeler
Licensed Embalmer No. 3512
P. O. Address Bethany 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.