DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23801

FILED AUG 9 1945

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 165

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole
(c) City or town Jefferson City, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 308 Marshall Street
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs. Nan Dudley Mabrey
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 Married
6. (b) Name of husband or wife Wm. C. Mabrey
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased September (Month) 2 (Day) 1880 (Year)

8. AGE: Years 64 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Potosi, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Thomas D. Castleman
13. Birthplace Not Known (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah McIlvaine
15. Birthplace Not Known (City, town, or county) (State or foreign country)
16. (a) Informant W. C. Mabrey
(b) Address Jefferson City, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July-30-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Potosi, Missouri
18. (a) Signature of funeral director Thorpe J Gordon
(b) Address Jefferson City, Missouri
19. (a) 7-28-45 (Date received local registrar) (b) Thorma Richter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1945 hour 2 minute A. M.
21. I hereby certify that I attended the deceased from 6-25-45, 19__, to 7-28-45, 19__; that I last saw her alive on 7-27-45, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ~~[illegible]~~ Chronic Myocarditis	
Due to Nephritis	
Due to Toxic Goiter	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 W. C. McKnelly (M. D. or other)
Address Jefferson City Mo Date signed 7-28-45

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 8-8-45

MAY 28 1953

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 Thomas J. Gordon

Licensed Embalmer No. 1786

P. O. Address Jefferson City 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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 165

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(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)

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

3. (a) PRINT FULL NAME Nan D. Mabrey

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 2 (Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 8
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to Chronic Nephritis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 13 1/2

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(a) Accident, suicide, or homicide (specify)

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(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 W. O. McKnelly (M. D. or other) MD

Address 405-6 Central Trust Bldg Jefferson City Mo Date signed Aug. 10, 1945

SUPPLEMENTARY

23801