S. No. -
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24804

State File No.

Registration District No. 297 Primary Registration District No. 4447 Registrar's No. 50

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Henrietta
(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 Missouri (b) County Ray 87

(c) City or town Henrietta
(If outside city or town limits, write "RURAL")

(d) Street No. 6
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 6

If yes, name country

3. (a) PRINT FULL NAME Mary Kathrine Listebarger

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Clyde L. Listebarger

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased May. (Month) 7 (Day) 1896 (Year)

8. AGE: Years	Months	Days	If less than one day
49	2	26	hr. min.

9. Birthplace Richmond (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Peter Kirk
13. Birthplace -------- (City, town, or county) Scotland (State or foreign country) 6

MOTHER
14. Maiden name Mary Jane Murray
15. Birthplace ---------- (City, town, or county) Irland (State or foreign country) 4

16. (a) Informant Clyde L. Listebarger
(b) Address Henrietta Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5. 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Richmond. Mo.

18. (a) Signature of funeral director E. Thurman
(b) Address Richmond. Mo.

19. (a) Aug 7 45 (Date received local registrar) (b) Mrs Chas W Shippard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 2 year 1945 hour 10 minute 30. P. M.

21. I hereby certify that I attended the deceased from June 1 - 1945 Aug 2 1945 that I last saw her alive on Aug 2 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Nephritis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(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 E. E. Fay (M. D. or other)

Address Richmond Date signed 8-5-45

12-80

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
istrict File Number
Filed 8-13-75

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, ###
Registered Apprentice No.
working under my personal supervision.

Signed E. Hinman

Licensed Embalmer No. 2073

P. O. Address Richmond. 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
1 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 14 1945

Registration District No. 297 Primary Registration District No. 4447 Registrar's No. 5 D

1. PLACE OF DEATH:

(a) County Ray Henrietta

(b) City or town (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 Mary K Listebarger

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 May 7 (Month) (Day) (Year)

8. AGE: Years 49 Months 2 Days 26 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 day 2 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	Duration
Chronic	
Due to	
Due to	
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 E. E. Gay (M. D. or other)

Address Richmond Date signed 8-17-45

SUPPLEMENTARY

OCT 15 1965