

FILED SEP 22 1945

Registration District No. 9 Primary Registration District No. 5-2915306 Registrar's No. 10

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

1. PLACE OF DEATH

(a) County Cole

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

(c) Name of hospital or institution In town
(If out in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 70 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

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

(d) Street No. In town
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Catherine Backers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased March 5 1861
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business at home

12. Name Gopa Beumle

13. Birthplace Hannover Germany
(City, town, or county) (State or foreign country)

14. Maiden name Upholde Wilmont

15. Birthplace Hannover Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Ed Backers
(b) Address Clatsop, Mo.

17. (a) Burial (b) Date thereof Sept 8 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Martins

18. (a) Signature of funeral director James Swain
(b) Address 293 Jefferson
(c) Date received local registrar 9/17/45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4 year 1945 hour 5 minute 10.0 M.

21. I hereby certify that I attended the deceased from Aug 10 1945 to Sept 4 1945 that I last saw her alive on Aug 30 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis
(Specify type of place)

Due to hypertension and arteriosclerosis 20 yrs

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy gbc

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 W. Merrifield (M.D. or other) _____ Address Clatsop, Mo. Date signed 8/24/45

Physician
Duration
Underline the cause to which death should be charged statistically.

A. Merryfield

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 *J. A. Anderson*
Licensed Embalmer No. *3641*
P. O. Address *gms*

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.