

No. 2  
-8-13  
5-17-39  
1 X37823

**FILED NOV 8 1945**  
Registration District No. 175

Primary Registration District No. 4275

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Marionville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: METHODIST HOME FOR THE AGED  
(If not in hospital or institution, write street, number, or location)  
(d) Length of stay: In hospital or institution 5 Six years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence  
(c) City or town Marionville  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Josephine Marie MAIRS

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 Widow  
7. Birth date of deceased Feb 21 1866  
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 15 If less than one day 1 am min.

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

10. Usual occupation home wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name ?  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Milburn M. Tisdale  
(b) Address Marionville Mo

17. (a) Burial (b) Date thereof Oct. 8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville, Mo.

18. (a) Signature of funeral director J. B. Bradford  
(b) Address Marionville, Mo.

19. (a) 10-9-45 (b) Ora McNett  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6  
year 1945 hour 1 am minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct. 5 1945 to Oct. 5 1945  
that I last saw her alive on Oct. 5 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
Due to Arteriosclerosis 2 yrs.

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 830

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:  
(c) 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: Wayne McNeave (M. D. or other) DO.  
Address Marionville, Mo Date signed 10/6/45

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

RECEIVED

District Health Officer No. 5.

District File Number 114 S-1080

Date Filed NOV 7 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

*Herman Surridge*

Licensed Embalmer No. 3072

P. O. Address Aurora 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.