

FILED NOV 30 1945

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 71

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

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Grim-Smith Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
(Specify whether in this community years, months or days) 18 days

3. (a) PRINT FULL NAME Ethel White

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 Single

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

7. Birth date of deceased: October 2, 1889  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

56 0 25 hr. \_\_\_\_\_ min.

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

10. Usual occupation: Housekeeper

11. Industry or business: Domestic

12. Name: George White

13. Birthplace: DK W. Va.  
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Sallee

15. Birthplace: Knox County Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant: Kate Austin

(b) Address: Rutledge, Mo.

17. (a) Burial (b) Date thereof: 10/28/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Rutledge Cemetery

18. (a) Signature of funeral director: John's Funeral Home

(b) Address: Kirkville, Mo.

19. (a) 10-30-45 (b) Kate Lambert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark

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

(d) Street No. Gen Del  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26 year 1945 hour 7 minute 40 P.M.

21. I hereby certify that I attended the deceased from 8 Oct 1945 to 26 Oct 1945  
that I last saw her alive on 26 Oct. 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Apexy, abdominal, multiple Duration: 3 weeks

Due to: Cause unknown.

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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:

(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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature: [Signature] (M. D. or other) M.D.  
Address: Kirkville, Mo. Date signed: 10-27-45

RECEIVED

District Health Officer No. 10

District File Number 11-45-1773

Date Filed NOV 27 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 Bowden Baaty

Licensed Embalmer No. 4379

P. O. Address Winksville, 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.