

FILED DEC 28 1945

Registration District No. 1179

Primary Registration District No. 1002

Registrar's No. 5077

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Keokuk Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
9007 Westport Road 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 16 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town Keokuk Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 9007 Westport Rd 8
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Thomas F. McMarrau

3. (b) If veteran, name war —

3. (c) Social Security No. 496-03-7861

4. Sex M | 5. Color or race wh

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

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

7. Birth date of deceased May 14 1879
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Utica New York
(City, town, or county) (State or foreign country)

10. Usual occupation Saluman

11. Industry or business Manor Bakery

12. Name James McMarrau

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

14. Maiden name Frances Nigh

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary McMarrau

(b) Address 9007 Westport Road

17. (a) burial (b) Date thereof Dec 11 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlaw

18. (a) Signature of funeral director Paul N. Roe

(b) Address 7706 Warrenton Rd

19. (a) 12-10-45 (b) St. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8th
year 1945 hour 5 minute 0 P. M.

21. I hereby certify that I attended the deceased from Oct 13, 1945, to Dec 8, 1945,
and that death occurred on the date and hour stated above.
That I last saw him alive on Dec 8, 1945;

Immediate cause of death Coronary occlusion Duration 2 days

Due to Coronary thrombosis 7 weeks

Due to _____

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

Major findings: Of operations 94a
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 E. W. Shusher (M. D. or other)
Address 900 Rialto Bldg Keokuk Mo Date signed 12-10-45

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

MOTHER FATHER

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. Smalton*

Licensed Embalmer No. *2744*

P. O. Address *N. C. 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.