S. No. 2
M—5-43
v. 5-17-39
1 X36671

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. 41433

FILED JAN 5 1946

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 130

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: West City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 406 N. Lowe (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether In this community 40 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper 49
(c) City or town: West City (If outside city or town limits, write "RURAL") 6
(d) Street No. 406 N. Lowe (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: Mary Elizabeth Machlan
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: Widowed
6. (b) Name of husband or wife: Widowed
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: March 22 1876 (Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace: Republic (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: at Home
11. Industry or business:
FATHER 12. Name: W. M. Mossingham
FATHER 13. Birthplace: Del (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Lethia Herrington
MOTHER 15. Birthplace: Mo 0 (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Velma Shields
(b) Address: Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Harrington Cemy
18. (a) Signature of funeral director: West City Mort Co
(b) Address: West City Mo
19. (a) 12/10/45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9 year 1945 hour 320 minute a. M.
21. I hereby certify that I attended the deceased from May 30 1945 to Dec 9 1945 that I last saw him alive on Dec 5 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary tuberculosis — Chronic	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 365

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: [illegible] (M. D. or other)
Address: West City Mo Date signed 12/10/45

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(Licensed Embalmer's Statement on Reverse Side)

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

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.