

FILED JAN 14 1946
Registration District No. 270

Primary Registration District No. S771

Registrar's No. 80

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Lineville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 60 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret Adella Bright

3. (b) If veteran, name war..... 3. (c) Social Security No. None

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

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

7. Birth date of deceased Nov. 4, 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 I 21 hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business Own Home

MOTHER FATHER
12. Name Joseph Larkins
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Johnson
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Maurice Bright
(b) Address Lineville Iowa

17. (a) Burial (b) Date thereof Dec. 27, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lineville, Iowa

18. (a) Signature of funeral director O. O. Lumber

(b) Address Lineville, Iowa

19. (a) 12-31-45 (b) Loan Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer
(c) City or town So. Lineville, Mo.
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25
year 1945 hour 4 min AM M.

21. I hereby certify that I attended the deceased from Dec 16 1945 to Dec 25 1945
that I last saw her alive on Dec 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 830
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) (a) Means of injury.....
23. Signature BE Lumber (M. D. or other)
Address Lineville Ia Date signed 12-27-45

1367

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

RECEIVED
District Health Officer No. 11;
District File Number
Date Filed

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

James L. Gravelle

Licensed Embalmer No.

3967

P. O. Address

Linnville, Va.

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.