

FILED FEB 15 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 133

Primary Registration District No. 5483

Registrar's No. 6

1. PLACE OF DEATH:

(a) County HARRISON
 (b) City or town RURAL BETHANY T.W.S.P.
 (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.....
 (Specify whether
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HARRISON 41
 (c) City or town RURAL 5
 (If outside city or town limits, write "RURAL")
 (d) Street No. BETHANY T.W.S.P. 6
 (If rural, give location)
 (e) Citizen of foreign country? No. 6 (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME JENNIE ADDIE WILCOX

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOW
 6. (b) Name of husband or wife ED. 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased 4 12 1876
 (Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day
69 9 6 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER

12. Name MARK HALDEN 1/4
 13. Birthplace SCOTLAND
 (City, town, or county) (State or foreign country)
 14. Maiden name MARY MAXWELL
 15. Birthplace WALES 4
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clyde Stratten 1
 (b) Address Bethany, Mo.

17. (a) BURIAL (b) Date thereof 1-30-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MIRIAM CEMETERY

18. (a) Signature of funeral director Thornton H. Haas

(b) Address Bethany, Mo.

19. (a) Jan 29-46 (b) Zola Burris
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
 year 1946 hour 2 minute 45 P.M.
 21. I hereby certify that I attended the deceased from Jan Dec 30
1946 to Jan 30, 1946
 that I last saw h.e.r. alive on Jan 19, 1946,
 and that death occurred on the date and hour stated above.

Immediate cause of death Memoria

Due to Chronic nephritis

Due to arteriosclerosis

Other conditions hemophilia, fracture forearm

Major findings:
 Of operations none
 Of autopsy none

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, list the following:

(a) Accident, suicide, or homicide (specify) 41
 (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 Thomas R. Rabb (M. D. or other) mds
 Address Bethany Hospital Date signed 29 Jan 46

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

MAY 10 1945

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Thomton H. Haas*

Licensed Embalmer No. *2861*

P. O. Address..... *Bethany, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 267
Registrar's No. 6

Registration District No. 133 Primary Registration District No. 5483

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Rural Bethany, Mo.
(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 _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jessie A. Wilcox
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased 12 yrs (Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months)
Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 12-30-45

(c) Where did injury occur? home - Harrison Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? about home - at farm

While at work? no (Specify type of place) (e) Means of injury Fall

23. Signature Thomas R. Robt. M.D. (M. D. or other)

Address Bethany, Mo. Date signed 2/17/46

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

SUPPLEMENTARY

MOTHER FATHER

745

MAY 10 1946

2832