

FILED FEB 15 1946

Registration District No. 274

Primary Registration District No. 21547

1. PLACE OF DEATH:

(a) County North
(b) City or town Grant city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 56 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North 113
(c) City or town Grant city
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CLARA ELIZABETH KIBBE

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

4. Sex f 5. Color or race w 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife John H. Kibbe 6. (c) Age of husband or wife if alive 87 years
7. Birth date of deceased Aug 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 8 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name James A. Robertson
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Schoeller
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John H. Kibbe
(b) Address Grant city, Mo.

17. (a) Burial (b) Date thereof 1-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant city con.

18. (a) Signature of funeral director A. C. Duffell
(b) Address Grant city, Mo.

19. (a) Jan 28 1946 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17
year 1946 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from Oct 1946 to Jan 17 1946
that I last saw her alive on Jan 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration of heart
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 928
Of autopsy no

Duration 5 yrs.
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? _____ (c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Grant city, Mo. Date signed 1-18-46

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

**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.....

Arch C. Duffee

Licensed Embalmer No. *3252*

P. O. Address:.....

Grant 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.