

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED MAR 29 1946

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9952
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 175
 (b) Township..... Primary Registration District No. 6-49 42 78
 or Pine City
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Julia Margaret Alyea

(a) Residence, No. Rural St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F. M.</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Frank Alyea</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 16, 1880</u>		
7. AGE	YEARS <u>65</u>	MONTHS <u>11</u>
	DAYS <u>4</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>House wife</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-20, 1946
 22. I HEREBY CERTIFY, That I attended deceased from 8/6/45, 19... to 9/19/46, 19...
 I last saw her alive on 2/19, 1946 Death is said to have occurred on the date stated above, at 29 m.
 The principal cause of death and related causes of importance were as follows:

Central Hypertrophy of the heart
HT hypertrophy
 Date of onset 2/17/46
 Other contributory causes of importance:
hypertension
arteriosclerosis
valvular disease of heart

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19...
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) F. J. Moering, M. D.
 (Address) Monett Mo

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Minnesota</u>
	13. NAME <u>Jacob Munschank</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
	15. MAIDEN NAME <u>Wentman</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
	17. INFORMANT <u>Frank Alyea</u> (ADDRESS) <u>Pine City, Mo.</u>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St Agnes, Sarosie</u> DATE <u>Feb 23</u> , 19 <u>46</u>
	19. FUNERAL DIRECTOR (NAME) <u>William Messall</u> (ADDRESS) <u>Pine City, Mo.</u>
	20. FILED <u>2/23</u> , 19 <u>46</u> . <u>Desmet</u> Local Registrar.

RECEIVED

District Health Officer No. 6,
District File Number 346-384

Date Filed MAR 25 1946

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 Gordon Bennett

Licensed Embalmer No. 4213

P. O. Address Cassville 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, above space should be left blank.