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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10454
Registrar's No. 48

FILED MAR 27 1946

Registration District No. 297 Primary Registration District No. 3056

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
704 So. Clark St. /
(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

3. (a) PRINT FULL NAME Mary E. Hager

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female / race White

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: July 21st 1851
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

95 7 1 _____ hr. _____ min.

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

10. Usual occupation: At home

MOTHER FATHER

11. Industry or business _____

12. Name Samuel Camery

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

14. Maiden name Sallie Scott

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

16. (a) Informant Maude Hager

(b) Address Moberly, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-26-46
(Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director Mahoney and Son

(b) Address Moberly, Mo

19. (a) Feb 26-46 (Date received local registrar) (b) Lead Williams (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Moberly
(If outside city or town limits, write "RURAL")

(d) Street No. 704 So Clark St. 3
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22nd
year 1946 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 2-20, 1946, to 2-22, 1946
that I last saw her alive on 2-22, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Small Intestine

Due to _____

Due to _____

Other conditions: ~~ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED~~

Major findings: _____

Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature W. Williams (M. D. or other) 0

Address Moberly, Mo Date signed 2-25-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

JUN 4 1946

RECEIVED APR 1 1946
District Health Officer No. 10
District File Number 3-46-608
Date Filed MAR-19-1946

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 Frank D. McNeill

Licensed Embalmer No.....

P. O. Address.....

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. April
Registrar's No. 48

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(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) (Specify whether

3. (a) PRINT FULL NAME Mary E. Hager

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 July 21 (Month) (Day) (Year)

8. AGE: Years 95 Months 7 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22 year 1946 hour _____ minute _____ M.

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

bowel obstruction
Due to Cause undetermined

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
1228
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) (e) Means of injury _____

23. Signature R.H. Williams (M. D. or other) _____

Address Moberly, Mo. Date signed _____

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

9367

SUPPLEMENTARY

JUN 4 1946

10454