

FILED MAY 14 1946

State File No. ....

Registration District No. 94

Primary Registration District No. 5377

Registrar's No. ....

1. PLACE OF DEATH:

(a) County DEKALB (GRANT TWP.)  
(b) City or town MAYSVILLE (RURAL)  
(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 LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County DEKALB 32  
(c) City or town MAYSVILLE (RURAL) 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANDREW JACKSON MARET

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife ANN MARET 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased MAY 14 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace GRANT TWP. DEKALB CO. MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name STEPHEN B. MARET /  
13. Birthplace KENTUCKY /  
(City, town, or county) (State or foreign country)  
14. Maiden name SARAH GREENAWALT  
15. Birthplace KENTUCKY /  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS VIOLA BURTON

(b) Address MAYSVILLE MO. R F D

17. (a) BURIAL (b) Date thereof 4-5-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WOODS CEMETERY

18. (a) Signature of funeral director PILCHER FUNERAL HOME

(b) Address MAYSVILLE MO.

19. (a) 4-5-46 (b) Roscoe Davidson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day #  
year 1946 hour 2 minute 25 A. M.

21. I hereby certify that I attended the deceased from June, 1942, to April 3, 1946  
that I last saw him alive on April 3, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Glomerulo Nephritis 3 yrs

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 130

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? h

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury h

23. Signature Dr. Harold Fowler (M. D. or other) D.O.  
Address MAYSVILLE MO. Date signed 4/5-46

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

11000

**DISTRICT HEALTH OFFICE  
Cameroon, 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 *[Handwritten Signature]*.....

Licensed Embalmer No. *3960*.....

P. O. Address *Waysville 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.**