

FILED JUN 7 1946

State File No. _____

Registration District No. _____

Primary Registration District No. 5255

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton, Clark Twp.
(b) City or town Marceline 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 63 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton
(c) City or town Marceline Mo
(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 Myrtle Bell Peden

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

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Thomas A. Peden
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased April 17 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 0 24 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James W. Curry
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ellen Cooper
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas A. Peden

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof May 10 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Peden Chapel

18. (a) Signature of funeral director James M. Haughler

(b) Address Marceline Mo

19. (a) May 11 1946 (b) Martha Clark
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11
year 1946 hour 11 minute 20 P.M.
21. I hereby certify that I attended the deceased from Aug 3, 1943 to May 11, 1946
that I last saw her alive on May 4, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the liver
Duration 3 mo.

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

Major findings:
Of operations _____
Of autopsy 46f
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 John W. Coker (M. D. or other) 2 DO
Address Marceline Mo Date signed 5-13-46

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

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 6-5-46

OCT 11 1950

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 Blanche M. Langille

Licensed Embalmer No. 1909

P. O. Address Maxceline M.

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.

Registration District No. 66

Primary Registration District No. 5255

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Marceline - 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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Myrtle B. Peder

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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

April 17
(Month) (Day) (Year)

8. AGE:

Years 63

Months _____

Days _____

If less than one day
hr. _____ min. _____

9. Birthplace _____

(City, town, or county)

(State or foreign country) MO

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) _____

(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) May 11 1946 (b) _____

(Date received local registrar)

Martha C. Clark
(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 _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____
Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

37
1. 2. 3.

10032