

S. No. 2
1-8-43
5-17-39
P 1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17657

FILED MAY 27 1946

Registration District No. 278

Primary Registration District No. 3054

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Pike County Hospital
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pike 82
(c) City or town Pike Co Hospital 81
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME MARY NOLAN GEERY

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

4. Sex F / Color or race W 5. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased: August 22 1903
(Month) (Day) (Year)

8. AGE: Years 43 Months 7 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Newton Anderson

13. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Keora Anderson

15. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Anderson
(b) Address Calix Mo

17. (a) Burial (b) Date thereof Apr 2 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lower Cemetery

18. (a) Signature of funeral director McLure Aldrich Co.
(b) Address Calix Mo
19. (a) Apr. 2nd 1946 - McLoosh Ditty
(Date received local registrar) (Registrar's signature)
Marjorie E. Stephens
(Licensed Embalmer's Statement on Reverse Side)
registered # 278

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on 3-31- 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Tetony

Due to Paralytic disease

Due to _____

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

Major findings: Of operations 63e
Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence none

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

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10001

RECEIVED
District Health Officer No. 10
District File Number 5-46702
Date Filed MAY-23-1946

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 Norman E. Yeack
Licensed Embalmer No. 2342
P. O. Address Edina, 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.

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. _____

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 (b) City or town _____
(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)

3. (a) PRINT FULL NAME

Mary N. Geery

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, Married

6. (b) Name of husband or wife Ray W. Geery 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased Aug. 22 1930
(Month) (Day) (Year)

8. AGE: Years 42 Months 7 Days 10 If less than one day, _____ hr. _____ min.

9. Birthplace _____
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Margaret E. Stephens
(Date received local registrar) (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 Aug year 1946 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 _____

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 _____

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

SUPPLEMENTARY

17657