

FILED JUL 29 1946

State File No. 23155

Registration District No. 78

Primary Registration District No. 5366

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Daviess
 (b) City or town Marion Missouri Twp
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Marion Twp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 7 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Daviess
 (c) City or town Bural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Marion Twp
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Francis Mae Barney

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 single

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

7. Birth date of deceased. Oct 1916
 (Month) (Day) (Year)

8. AGE: Years 29 Months 8 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Daviess Co. MO
 (City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

12. Name Alvin Barney

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

14. Maiden name Berna Cain

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

16. (a) Informant Mr Berna Cain Barney

(b) Address Pattersonburg MO

17. (a) Burial (b) Date thereof June 19-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Best Chapel

18. (a) Signature of funeral director S. Brown
 (b) Address Pattersonburg MO
 19. (a) 6-29-46 (b) W. E. Engelbert
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
 year 1946 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 28
1946 to June 17 1946;
 that I last saw her alive on June 17 1946;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Attack of Asthma
 Due to Accidental fall & injury to back & right leg
 Due to Tuberculosis

Other conditions Myocarditis
 (include pregnancy within months of death)

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)
 or Means of injury _____

23. Signature B. Lee Shubert (M.D. or other)
 Address Box 907, Pattersonburg MO Date signed 6-18-46

Duration

years

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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 *Ed Brown*

Licensed Embalmer No. 2884

P. O. Address. Pattersonburg 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. 98

Primary Registration District No. 5366

1. PLACE OF DEATH:

(a) County Daviess

(b) City or town 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 _____
years, months or days

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 _____

3. (a) PRINT FULL NAME Francis M. Ramey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 8
(Month) (Day) (Year)

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

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

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) _____ (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) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from June 17th
1946 to June 17th 1946
that I last saw him alive on June 17th 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Asthmatic Attack Duration 2.0 Min

Due to General Debilitation Months

Due to Fall & injury to right femur one day

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

Major findings:
Of operations _____

Of autopsy 112

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) no

(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 B. Lee Shelton (M. D. or other) M.D.
Address Box 207, Pettowbury Date signed 8-4-46

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

SUPPLEMENTARY

