

**FILED SEP 14 1946**

Registration District No. **07** Primary Registration District No. **3038**

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

1. PLACE OF DEATH:

(a) County **Linn**  
(b) City or town **Brookfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Mc Kamey Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5 hours**  
(Specify whether  
In this community   
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Macon**  
(c) City or town **New Cambria "Rural"**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5 miles south of New Cambria**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **1**

3. (a) PRINT FULL NAME **MARY MILDRED HENRY**

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 **Arthur Henry** 6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **October 4, 1894**  
(Month) (Day) (Year)

8. AGE: Years **51** Months **10** Days **13** If less than one day hr. min.

9. Birthplace **New Cambria Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Lincoln Beale**

13. Birthplace **West Haven, W. Va.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Belle Sumner**

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

16. (a) Informant **Arthur Henry**

(b) Address **New Cambria Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 19, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Cambria Cemetery at home**

18. (a) Signature of funeral director **H. G. Hillebrand**

(b) Address **New Cambria Mo.**

19. (a) **9/19/46** (b) **W. B. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **17**  
year **1946** hour **1** minute **12** A.M.

21. I hereby certify that I attended the deceased from **8-1-**  
**1946**, to **8-17**, 19**46**  
that I last saw her alive on **8-27**, 19**46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal hemorrhage**

Due to **Multiple gunshot wounds of abdomen**

Due to **1640**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Fracture of liver**  
**No. of intestines (9)**  
Of autopsy **1640**

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) **suicide**

(b) Date of occurrence **8-16-46 5:00 P.M.**

(c) Where did injury occur? **New Cambria, Macon, Mo.**  
(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) (c) Means of injury **22 rifle**

23. Signature **Prof. P. Busch** (M. D. number)

Address **Brookfield Mo.** Date signed **8-17-46**

26503

**DISTRICT HEALTH OFFICE  
Cameron, 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..... *H. J. Gilleland* .....

Licensed Embalmer No. *4019* .....

P. O. Address..... *New Cambria, 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.**