

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29277

Registration District No. 325

Primary Registration District No. 4480

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Schuyler
 (b) City or town Greentop
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 77 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler
 (c) City or town Greentop
 (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 _____

3. (a) PRINT FULL NAME MARY ELIZABETH HICKS

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 Widow

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

7. Birth date of deceased: Nov. 2 1868
 (Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation: House wife

11. Industry or business: House

12. Name: Fredrick M. Shelton

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

14. Maiden name: Elizabeth Spinning

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

16. (a) Informant: Wm. Shelton

(b) Address: Greentop, Mo.

17. (a) Burial (b) Date thereof: Nov. 14-1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Greentop, Schuyler Co. Mo.

18. (c) Signature of funeral director: Wm. Shelton

(b) Address: Queen City, Mo.

19. (a) Aug 13-1946 (b) Miss. J. Proctor
 (Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12
 year 46 hour 4 minute 10 P.M.
 21. I hereby certify that I attended the deceased from Aug 1-1946
 _____, 19____, to Aug 12-1946
 _____, 19____, that I last saw him alive on Aug 12, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
 Due to: Pneumonia
 Due to: _____

Other conditions: _____
 (Includes pregnancy within months preceding death)
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
 SUPPLEMENTARY INFORMATION REQUESTED - ON

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 2
 23. Signature: Wm. Shelton M.D. or other _____
 Address: Greentop Date signed: 11/14/46

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

JUN 11 1947

CHARLES ALBERT HARRIS

RECEIVED
District Health Officer No. 10
District File Number 8-46-1603
Date Filed AUG 21 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 self

Registered Apprentice No. _____

working under my personal supervision.

Signed Wm W West

Licensed Embalmer No. 2882

P. O. Address Incinnity 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. 325 Primary Registration District No. 4480

1. PLACE OF DEATH:
(a) County Schuyler
(b) City or town Greenleaf
(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 Mary E. Hicks
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 wid

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

7. Birth date of deceased Nov 2 1886
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____ (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)

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 1946 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ alive on _____ 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 107

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 Ed. H. ... (M. D. or other) _____
Address Law Center ... Date signed 7/25/46

SUPPLEMENTARY

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

28/15

29277

JUN 11 1967