

No. 2
-5-43
5-17-39
X36871

FILED SEP 10 1946

State File No. _____

Registration District No. 337

Primary Registration District No. 4499

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Shelby County
 (b) City or town Shelbina, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None (Specify whether)
 In this community Bertha May Todd
 years, months or days Entire life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby 102
 (c) City or town Shelbina 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Bertha May Todd

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26th
 year 1946 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 15, 1946 to Aug. 26, 1946
 that I last saw him alive on Aug 26
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Arthur Todd 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased July 11th 1896
 (Month) (Day) (Year)

Immediate cause of death acute hepatitis Duration 2 wks.

Due to _____

Due to _____

Other conditions Heart trouble
 (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

50 1 15 hr. min.

9. Birthplace Scotland Co., Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name A. J. Reynolds

13. Birthplace Kentucky
 (State or foreign country)

14. Maiden name Martha Anderson
 (State or foreign country)

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
 Of operations ASC

Of autopsy _____

16. (a) Informant Arthur Todd
 (b) Address Shelbina, Missouri

17. (a) Burial (b) Date thereof 8-28-1946
 (Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina, Missouri

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? _____

18. (a) Signature of funeral director Million & Barkeley
 (b) Address Shelbina, Missouri

19. (a) 8-31-46 (b) Ruth Jayner
 (Date received local registrar) (Registrar's signature)

(Specify type of place) _____

While at work? _____ (Specify type of place) _____

23. Signature R. L. Caldwell (M.D. or other) Do.
 Address Shelbina, Mo. Date signed Aug 30

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

RECEIVED
District Health Officer No. 10
District File Number 9-46-1649
Date Filed SEP-7-1946

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 *E. W. Hawkins*
Licensed Embalmer No. 3498
P. O. Address Shelburne 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. 337 Primary Registration District No. 2499

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Shelburna
(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 Bertha M. Todd
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 M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased July 11 (Month) (Day) (Year)
8. AGE: 50 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 _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Aug 31 1946 (b) Ruth J. [Signature]
(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 day 19 year 1946 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____ to _____ 19____; that I last saw him/her 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 _____

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) (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

29307