

Registration District No. 207

Primary Registration District No. 4319

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Belle
(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 years, months or days) 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries
(c) City or town Belle
(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 Francis Branson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Female 5. Color of White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband Thomas Branson 6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased May 11 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Osage County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

12. Name George Branson
13. Birthplace Missouri
14. Maiden name MARYA MESSEY
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant George Branson
(b) Address Belle - Mo.
17. (a) Burial (b) Date thereof OCT 12 - 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation home
18. (a) Signature of funeral director Pauline Haworth While at work _____
(b) Address Belle Mo. (c) Means of injury fall
19. (a) 10-17-46 (b) Pauline Haworth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10 year 1946 hour _____ minute 3:25 P.M.

21. I hereby certify that I attended the deceased from Oct 9 to Oct 10 1946
that I last saw her alive on Oct 9 1946
and that death occurred on the date and hour stated above

Immediate cause of death fractured femur & pneumonia
tuberc

Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none Of operations _____
Of autopsy no
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence OCT 1 - 1946
(c) Where did injury occur? Belle Maries Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home (Specify type of place)

Signature W. Jones (M. D. or other) _____
Address Belle Mo Date signed OCT 17/46

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10-21-46

NOV 26 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.....
Chester Lassmann

Licensed Embalmer No. 4178

P. O. Address Bland - 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.