No. 2
4-13-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 17 1946

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34278

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 147

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Frances Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days) In this community 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew
(c) City or town near Savannah (If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) If foreign born, how long in U. S. A.? no years.

3. (a) PRINT FULL NAME Allice Marie McGraw
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased un known (Month) (Day) (Year)
8. AGE: Years 74 Months — Days — If less than one day hr. min.
9. Birthplace un known (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business
MOTHER FATHER
12. Name un known
13. Birthplace un known (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name un known
15. Birthplace un known (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Leslie Burns
(b) Address Savannah mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Savannah
18. (a) Signature of funeral director E. C. Greer
(b) Address Savannah mo
19. (a) Oct 5, 1946 (Date received local registrar) (b) Ben Holt (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27 year 1946 hour 11 minute 50 P. M.
21. I hereby certify that I attended the deceased from 13 yr, 1946, to 27 Sept, 1946, that I last saw her alive on 26 Sept 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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)
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Lowell Burns (M. D. or other)
Address Savannah Mo Date signed 30 Sept 46

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(Licensed Embalmer's Statement on Reverse Side)

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.