

S. No. 2
M-5-43
5-17-39
K3687

State File No. _____

FILED JAN 13 1947

Registration District No. 47

Primary Registration District No. 3757

Registrar's No. 431

1. PLACE OF DEATH

(a) County CALLAWAY

(b) City or town RURAL STEEDMAN
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.F.D. 1
(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)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME EDNA J. PASLEY

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 C.C. PASLEY

6. (c) Age of husband or wife if alive DK. years

7. Birth date of deceased: MAR. 12 1889
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>57</u> | <u>9</u> | <u>18</u> | hr. _____ min. _____ |

9. Birthplace MONTGOMERY CO. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name JOSEPH INGRAM

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

14. Maiden name ERIZA DAVIS

15. Birthplace MONTGOMERY CO. MO.
(City, town, or county) (State or foreign country)

16. (a) Informant C.C. PASLEY

(b) Address MOKANE, MO.

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof JAN. 2. 1947
(Month) (Day) (Year)

(c) Place: burial or cremation STEEDMAN

18. (a) Signature of funeral director Glen J. Maupin

(b) Address 712 Court St. Fulton, MO.

19. (a) Jan 2/1947 (Date received local registrar)

(b) Joie Mauschel (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY

(c) City or town STEEDMAN RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1946 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from 10-18, 1946 to 12-31, 1946
that I last saw h. alive on 12-31, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Terminal Pneumonia
Jocosity Hip fracture

Due to _____

Due to _____

Other conditions: Tuberculosis
(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? _____

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature W O Payne (M. D. or other) _____
Address R # 6 Fulton Date signed FT-67

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

Date Filed JAN 8 1947

District File Number _____

District Health Officer No. 9

RECEIVED

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 Glen Y. Manger

Licensed Embalmer No. 2725-

P. O. Address Fulton, 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. 47 Primary Registration District No. 5157

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Russell
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

Edna J. Pasley

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 mar (Month)

12 (Day) 1902 (Year)

8. AGE: Years 57 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county)

Mo (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) _____ (Burial, cremation, or removal)

(b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

(b) _____ (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 _____, 19____; to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to suicide
in home

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

38640

SUPPLEMENTARY

39826