

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 43185

FILED DEC 24 1946  
Registration District No. 324

Primary Registration District No. 6093

Registrar's No. 203

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Marshall, Mo. *Rural*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Saline Co. Home *5*  
(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 All Her Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Saline *97*

(c) City or town Marshall *?*  
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. *1*  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) *0*  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Miss Betty McMahan

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 Single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Aug. 5, 1868  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>78</u>	<u>II</u>	<u>26</u>	_____ hr. _____ min.

9. Birthplace Arrow Rock Mo. *(1)*  
(City, town, or county) (State or foreign country)

10. Usual occupation ##### Did not Work

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Unknown *1*

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Hazel Green

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof 12/5/46  
(Method, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Marshall, Mo.

19. (a) 12-5-46 (b) Mo. T. Underbrook  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 12 day 2  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Sept 1  
1946, to Dec 2, 1946  
that I last saw her alive on Nov 26, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Thromboplegia *1st*  
Hypertension

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: \_\_\_\_\_ *83P*

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 [Signature] (M. D. or other) *0*

Address Marshall Date signed 12/5/46

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 12-21-46

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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 \_\_\_\_\_

Licensed Embalmer No. 32350

P. O. Address Marshall, W. Va.

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

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