No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2115

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 31

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 819 So 4th St
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph 88
(c) City or town Moberly 6
(If outside city or town limits, write "RURAL")
(d) Street No. 819 So. 4th St 3
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Abbie McCanne
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 Widowed
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Jan (Month) 18th (Day) 1865 (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	—	11	hr. min.

9. Birthplace ..... (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation At Home
11. Industry or business .....
FATHER
12. Name George Riddings
13. Birthplace ..... (City, town, or county) ? (State or foreign country) 9
MOTHER
14. Maiden name Susan Hershman
15. Birthplace ..... (City, town, or county) ? (State or foreign country) 9
16. (a) Informant Mrs Odell Mason
(b) Address Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-47 (Month) (Day) (Year)
(c) Place: burial or cremation Moberly. Mo
18. (a) Signature of funeral director Mahan and Sar
(b) Address Moberly Mo
19. (a) 1/30/47 (Date received local registrar) (b) Leah Williams Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29th. year 1947 hour 9 minute 50 M.
21. I hereby certify that I attended the deceased from Dec. 31/46 to Jan. 29/47 that I last saw be alive on Jan. 28 — 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis,	months,
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Acute Enteritis.	a wk

Major findings:
Of operations
Of autopsy
93 E

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) No
(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 No 0
23. Signature Dr L E Hoover M.D. (M. D. or other)
Address Moberly Mo Date signed 1/30/47

269 (Licensed Embalmer's Statement on Reverse Side)

RE... Officer No. 10
District ... 2:47:250
Date Filed FEB - 5 1947

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 Frank D DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.