

Registration District No. 316

Primary Registration District No. 4462

Registrar's No. 46

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 50 years years, months or days

3. (a) PRINT FULL NAME Rachel Montgomery

3. (b) If veteran, name war L

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Caucas

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John Montgomery

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased April 9 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>10</u>	<u>3</u>	hr. min.

9. Birthplace Washington County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business L

MOTHER FATHER

12. Name UNKNOWN

13. Birthplace UNKNOWN 7
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant Elsie Gibson

(b) Address Fluinnis, Mo.

17. (a) Burial (b) Date thereof Feb-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAMILTON CEMET

18. (a) Signature of funeral director SPARTS FUNERAL HOME

(b) Address 300 Taylor Flat River Mo.

19. (a) 2-14-47 (b) Cether Kullhoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94

(c) City or town FLUINNIS 3
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12 Th
year 1947 hour 11:45 minute _____ A.M.

21. I hereby certify that I attended the deceased from Dec 12
1947 to Feb 12, 1947
that I last saw her alive on 2-12-47, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Arteriosclerosis

Due to _____

Due to Senility

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____

Of autopsy AM

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 J.W. Hartman (M. D. or other) MD
Address Dismant, Mo. Date signed 2-14-47

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

RECEIVED

Health Officer No. 4
File Number 247-278
ed. 2-25-47

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 Everett Sparks
Licensed Embalmer No. 4287
P. O. Address Flat River 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.