

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7692**

FILED FEB 24 1947
Registration District No. **7A**

Primary Registration District No. **6272**

Registrar's No. **14**

1. PLACE OF DEATH:

(a) County **North**
(b) City or town **Rural - Allen Twp.**
(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 **none** (Specify whether)
In this community **35 yrs**
years, months or days

3. (a) PRINT FULL NAME **MARY KATHY R. PACKER**

3. (b) If veteran, name war **1918-1919** 3. (c) Social Security No. **1-1-1**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Amos Packer** 6. (c) Age of husband or wife if alive **79** years
7. Birth date of deceased **June 5 1872**
(Month) (Day) (Year)

8. AGE: Years **71** Months **6** Days **26** If less than one day
hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Edwin Brown**
13. Birthplace **NY State**
(City, town, or county) (State or foreign country)
14. Maiden name **Lidia Miller**
15. Birthplace **Denver**
(City, town, or county) (State or foreign country)

16. (a) Informant **Neelie P. H. Gager**
(b) Address **North MO**

17. (a) **Burial** (b) Date thereof **Feb 3 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kent Cemetery**

18. (a) Signature of funeral director **Brane Bros**

(b) Address **Denver CO**

19. (a) **Feb-14-47** (b) **Leta E. Dawson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **North**
(c) City or town **Denver** (Rural) (If outside city or town limits, write "RURAL")
(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 **1**
year **1947** hour **3** minute **15** AM.

21. I hereby certify that I attended the deceased from **Jan 10 1945** to **Feb 1 1947**
that I last saw her alive on **Feb 1 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Pectonics**
Due to **Old age & Hypertension**

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

2 days

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 **Charles Williamson** (M. D. or other)
Address **Denver MO** Date signed **2-12-47**

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.....

J. P. Bran
Licensed Embalmer No. *2847*

P. O. Address.....

Denver, 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.