

FILED MAR 24 1947

Registration District No. **2**

Primary Registration District No. **5314**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **COOPER**
 (b) City or town **RURAL PRAIRIE HOME**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
PRAIRIE HOME MO.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **88 yr** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER 27**
 (c) City or town **RURAL**
 (If outside city or town limits, write "RURAL")
 (d) Street No **NEAR PRAIRIE HOME MO**
 (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) FULL NAME **NANCY E. MENEFFEE**

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 **DEAD** years

7. Birth date of deceased **10 24 1858**
 (Month) (Day) (Year)

8. AGE: Years **88** Months **4** Days **25** If less than one day _____ hr. _____ min.

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

10. Usual occupation **RETIRED**

11. Industry or business _____

12. Name **W^m Taylor**

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

14. Maiden name **HUNT**

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

16. (a) Informant **Dr. J. Meredith**

(b) Address **Prairie Home mo.**

17. (a) **RETIRED** (b) Date thereof **2-22-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WALNUT GROVE CEM**

18. (a) Signature of funeral director **C. Albert Hornbeck**

(b) Address **Prairie Home mo.**

19. (a) **2-24-47** (b) **J. Meredith**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **19**
 year **1947** hour **9** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **March 19, 1947** to **March 19, 1947**
 that I last saw her alive on **March 10, 1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic** Duration _____
Valvular Disease
of Heart

Due to _____

Due to _____

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

Major findings:
 Of operations **13D**

Of autopsy _____

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 **0**

23. Signature **J. Meredith** (M. D. or other) _____

Address **Prairie Home mo.** Date signed **3-24-47**

MOTHER FATHER

012

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.....

C. Albert Hornbeck

Licensed Embalmer No.

2714

P. O. Address.....

Prairie Home

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 8

Registration District No. 82

Primary Registration District No. 5314

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days
3. (a) PRINT FULL NAME Nancy E. Menefee
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 24
(Month) (Day) (Year)

8. AGE: Years 88 Months _____ Days _____ (If less than one day) _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 3-27-47 (b) W. H. Mendenhall
(Date received local registrar) (Registrar's signature)

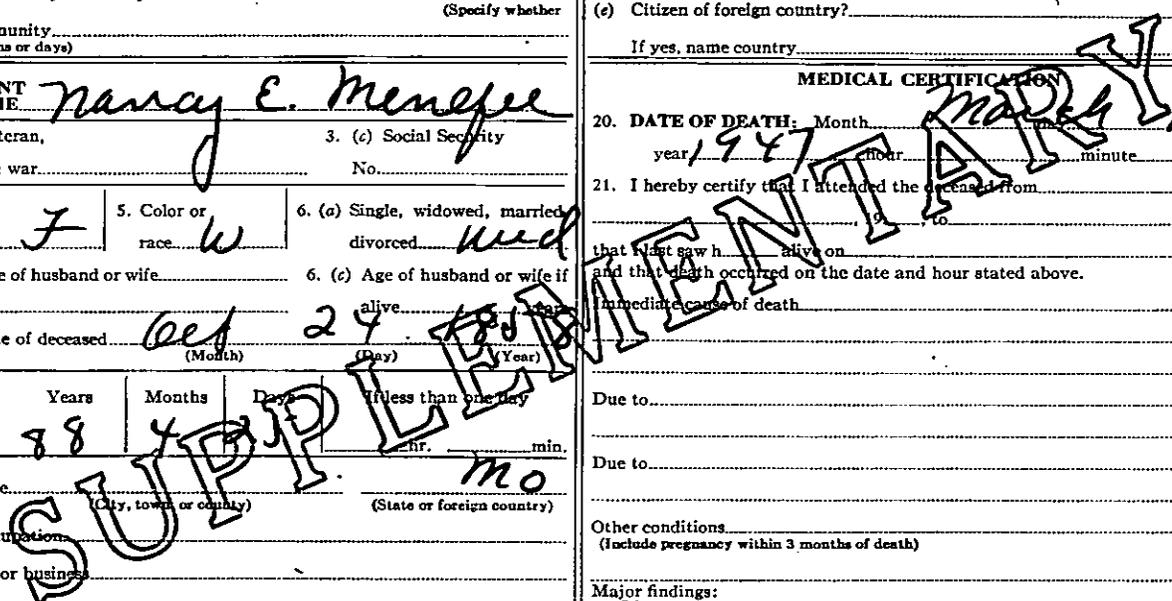
2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March 1947
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings:
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 _____ (M. D. or other) _____
Address _____ Date signed _____



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