

FILED APR 21 1947

Registration District No. **104**

Primary Registration District No. **3032**

Registrar's No. **4**

1. PLACE OF DEATH:
 (a) County: **Johnson**
 (b) City or town: **Warrensburg Mo**
 (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: **40** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: **Mo** (b) County: **Johnson**
 (c) City or town: **Warrensburg** (If outside city or town limits, write "RURAL" and name of township)
 (d) Street No.: **316 Mc Sorbonne** (If rural, give location)
 (e) Citizen of foreign country? **✓** (Yes or No)
 If yes, name country: **✓**

3. (a) **PRINT FULL NAME** **Mary Jane Estes**
 3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **4** day **12** year **1947** hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from **12** to **12** 19**47** and that I last saw her alive on **apw 12** 19**47** and that death occurred on the date and hour stated above.
 Immediate cause of death: **cerebrovascular disease**
 Due to: **Senility**

4. Sex: **Female** 5. Color or race: **W**
 6. (a) Single, **Widow**, married, divorced
 6. (c) Age of husband or wife if alive: **4 - 4 - 1858**
 7. Birth date of deceased: (Month) **4** (Day) **4** (Year) **1858**

Other conditions (include pregnancy within 3 months of death): _____
 Major findings: _____
 Of operations: _____
 Of autops: **none**
 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? _____ (Specify type of place) _____
 While at work? _____ (Specify type of place) _____
 Means of injury _____
 Signature: **J. M. Patterson** (M.D. or other) _____
 Address: **Warrensburg Mo** Date signed: **7-12-47**

8. AGE: Years **91** Months **0** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace: **Johnson Mo** (City, town, or county) (State or foreign country)
 10. Usual occupation: **Housekeeping**

11. Industry or business: _____
 12. Name: **James Marshall**
 13. Birthplace: **Mo** (City, town, or county) (State or foreign country)
 14. Maiden name: **Elizabeth Taylor**
 15. Birthplace: **Mo** (City, town, or county) (State or foreign country)

16. (a) Informant: **Russell Estes**
 (b) Address: **Denver Co**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof: **4-14-47** (Month) (Day) (Year)
 (c) Place: burial or cremation: **Hockey Cem**

18. (a) Signature of funeral director: **Fred Wellburn**
 (b) Address: **Warrensburg Mo**
 19. (a) **Apr 12, 1947** (Date received local registrar) (b) **James Marshall** (Registrar's signature)

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

MOTHER: FATHER:

PHYSICIAN
 Underline the cause of which death should be charged statistically.

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.....

Fred Welles

Licensed Embalmer No.....

2478

P. O. Address.....

Clinton 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Mo 9Registration District No. 164Primary Registration District No. 2022Registrar's No. 41

1. PLACE OF DEATH:

- (a) County Johnson
 (b) City or town Warrensburg
 (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 _____ years, months or days)

3. (a) PRINT FULL NAME Mary Jane Ester

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 _____

7. Birth date of deceased April 4 (Month) (Day) (Year)

8. AGE: Years 91 Months _____ Days _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation housekeeping

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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
 (Date received local registrar)

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 _____ year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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)

- Major findings: Of operations _____

- 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 _____

23. Signature _____ (M. D. or other) _____

- Address _____ Date signed _____

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

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