

FILED APR 18 1947

Registration District No. 248

Primary Registration District No. 4369

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Sereca
(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 years, months or days)
In this community 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Newton 73
(c) City or town Sereca 4
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth Gibbons
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 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 31, 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 7 7 hr. _____ min.

9. Birthplace Montevella Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Billy Price
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rosetta Robinson
(b) Address Sereca, Mo.
17. (a) Burial (b) Date thereof April 10, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sereca, Mo.
18. (a) Signature of funeral director W E Biddlecome
(b) Address _____
19. (a) April 12 - 1947 (b) Nettie Norris
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 8
year 1947 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from March 1947 to April 8 1947
that I last saw her alive on April 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
hypertension
Due to chronic hypertension
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 3 B
Of autopsy _____

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 W Biddlecome (M. Director)
Address Sereca Mo. Date signed 4-10-47

MOTHER FATHER

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

RECEIVED

District Health Officer No. Nanters

District File Number 447-~~70~~77

Date Filed X-15-47

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 W E Biddlecom

Licensed Embalmer No. 2174

P. O. Address Seneca NY

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.

Registration District No. 248

Primary Registration District No. 4369

Registrar's No. _____

1. PLACE OF DEATH: newton
(a) County _____
(b) City or town Seneca
(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 Elizabeth Gibbons
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 aug 31
(Month) (Day) (Year)
8. AGE: Years 90 Months 7 Days 2 (If less than one day, hr. min.)

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

10. Usual occupation _____
11. Industry or business Housewife

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) May 12 1947 (b) Mrs Nettie Norris
(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 _____ 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 _____

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 _____

SUPPLEMENTARY

14365