

FILED APR 29 1947

State File No. _____

Registration District No. 390

Primary Registration District No. 6014

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
 (b) City or town Higbee Mo. 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 years, months or days)
 In this community 78yrs 0mo 20 da

3. (a) PRINT FULL NAME Mrs Martha Oconnor.

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 Married

6. (b) Name of husband or wife Mike Oconnor 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased Feb 22 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>0</u>	<u>20</u>	hr. min.

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

10. Usual occupation House Wife.

11. Industry or business _____

12. Name John Ferril

13. Birthplace Randolph Co.
(City, town, or county) (State or foreign country)

14. Maiden name Pauline Griffey.

15. Birthplace Columbia Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mike Oconnor

(b) Address R. F. D. Higbee Mo.

17. (a) Burial (b) Date thereof Mar 12 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burton Cem Higbee Mo.

18. (a) Signature of funeral director Joe W Burton

(b) Address Higbee Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
 (c) City or town Higbee Mo. Rural
(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 Mar day 10
 year 1947 hour 2 minute 10 a.m.

21. I hereby certify that I attended the deceased from March 1, 1947 to Mar 8, 1947
 that I last saw h. er. alive on March 8, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
 Duration 3 yrs

Due to arterio-sclerosis & Hypertension

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy 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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature W. Dreyer (M. D. or other) MD
 Address Huntsville Mo Date signed 3/12/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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

Edw. Fremont

Licensed Embalmer No. *3978*

P. O. Address *Glasgow 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.

Registration District No. 390 Primary Registration District No. 6014

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

1. PLACE OF DEATH Randolph Rural
 (a) County Randolph
 (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 _____ years, months or days) (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Martha O'Connor
 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 m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased set 22 1906
 (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ (Unless 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) _____ (b) _____
 (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. 10

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 6/24/47

SUPPLEMENTARY

14057