

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Wagoner  
(b) City or town Chickerington  
(c) Name of hospital or institution State Hospital # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr 5 mo 5 days  
In this community 1 yr 5 months 5 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MARIAM PERSYM

3. (b) If veteran, name war.  3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widow, 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 11-24-1866  
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 8 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business ✓

12. Name Margaret Banks

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

14. Maiden name Augusta Rogers

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

16. (a) Informant Hospital record  
(b) Address Wagoner, Mo.

17. (a) Removal (b) Date thereof 4-3-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wagoner City Mo.

18. (a) Signature of funeral director Beiberg Funeral Home  
(b) Address Wagoner Mo.  
19. (a) 4-5-47 (b) Rathbone Vancuy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3129 Fairfield  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2  
year 1947 hour 1 minute 14 P. M.

21. I hereby certify that I attended the deceased from 9-30-46, 1946 to 4-2-, 1947  
that I last saw her alive on 4-2-, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cardio-renal disease  
(Include pregnancy within 5 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy 907

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? \_\_\_\_\_

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

23. Signature R. G. Hall (If not other) \_\_\_\_\_  
Address Wagoner Mo Date signed 4-5-47

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

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**RECEIVED**  
District Health Officer No. 7,  
~~District File Number 3-47-466~~  
~~Date Filed 4-17-47~~

**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 Mark E. Hughes  
Licensed Embalmer No. 2656  
P. O. Address Quincy, 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, above space should be left blank.**