

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
FILED MAY 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18378

State File No. ....

Registration District No. 279

Primary Registration District No. 5957

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Pike  
(b) City or town Eolia Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: RFD # 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Entire Lifetime - 86 yrs years, months or days

3. (a) PRINT FULL NAME Mary Florence Atkins  
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 W 2  
6. (b) Name of husband or wife William Douglas Atkins 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 26 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 2 6 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name James W Johnson  
13. Birthplace Not known 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Arrend Washam  
15. Birthplace Pike Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Achor  
(b) Address Eolia Mo  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 1947  
(Month) (Day) (Year)  
(c) Place: burial or cremation Eolia Mo

18. (a) Signature of funeral director Norman E. Gooch  
(b) Address Eolia Mo  
19. (a) May 3-1947 (b) N.E. Gooch - Deputy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike 82  
(c) City or town Eolia, Mo 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day and  
year 1947 hour 8 minute 30 A M.

21. I hereby certify that I attended the deceased from Mar 1st 1947 to May 2nd 1947.  
that I last saw him alive on May 2nd 1947.  
and that death occurred on the date and hour stated above.

Immediate cause of death Cervary Occlusion

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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 \_\_\_\_\_

23. Signature J. B. Biggs, M.D. (M. D. or other)  
Address Blanchard, Mo. Date signed 5/3/47

AUG 13 1948

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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 Norman E. Gooch

Licensed Embalmer No. 2342

P. O. Address Osalia, 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.**