

S. No. 2  
M-5-43  
7-3-17-39  
I X36871

FILED JUL 29, 1947

Registration District No. \_\_\_\_\_ Primary Registration District No. **4322**

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

1. PLACE OF DEATH  
 (a) County **Mercer**  
 (b) City or town **Ravanna, Mo**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **no**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **no** (Specify whether years, months or days) **all her life**

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Mercer**  
 (c) City or town **Ravanna, Mo**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Joanna Martin**  
 3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**  
 4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Jan 5, 1856**  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **July** day **12** year **1947** hour \_\_\_\_\_ minute \_\_\_\_\_ AM.  
 21. I hereby certify that I attended the deceased from **July 12**, 19**47** to **July 12**, 19**47**  
 that I last saw her alive on **July 12**, 19**47** and that death occurred on the date and hour stated above.

8. AGE: Years **89** Months **6** Days **7** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **chronic nephritis**  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
 Of autopsy **no**  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

10. Usual occupation **housekeeper**

11. Industry or business \_\_\_\_\_

12. Name **King**  
 13. Birthplace **Ohio**  
 (City, town, or county) (State or foreign country)

14. Maiden name **unknown**  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant **Howard Clark**  
 (b) Address **Ravanna, Mo**

17. (a) **burial** (b) Date thereof **July 13, 1947**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ravanna**

18. (a) Signature of funeral director **Princeton, Mo Noel Moss**  
 (b) Address \_\_\_\_\_

19. (a) **7/12/47** (b) **M. J. Ruth**  
 (Date received local registrar) (Registrar's signature)

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) (e) Means of injury \_\_\_\_\_

23. Signature **J. M. Perre**  
 Address **Princeton, Mo** Date signed **7/12-47**

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Del Mass

Licensed Embalmer No. 263x

P. O. Address Princeton 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.**