

No. 2  
5-43  
5-47-39  
I-238671

FILED AUG 4 1947

State File No.

Registrar's No. 13

Registration District No. 258

Primary Registration District No. 4374

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

1. PLACE OF DEATH

(a) County Madawney

(b) City or town Clyde Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of ~~hospital~~ institution:  
Benedictine Convent  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In ~~hospital~~ institution 56 years  
(Specify whether)

In this community 56 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madawney

(c) City or town Clyde 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 Sister Mary Elizabeth Laver

3. (b) If veteran, name war ✓

3. (c) Social Security No. NON E

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18  
year 1947 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 1  
1947, to July 18 1947;  
that I last saw h.c.v. alive on July 13 1947;  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 9 1862  
(Month) (Day) (Year)

Immediate cause of death ad cerebral thrombosis chronic myocarditis

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

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

8. AGE: Years 85 Months 1 Days 9  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions senility  
(Include pregnancy within 3 months of death)

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

Major findings:  
Of operations ✓

Of autopsy ✓

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

10. Usual occupation Domestic

11. Industry or business Sister in Convent

12. Name Mathias Laver

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

14. Maiden name Anna Maria Mueller

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

16. (a) Informant Mathias Laver

(b) Address Benedictine Convent Clyde Mo

17. (a) Buried (Burial, cremation or removal) (b) Date thereof 7/22/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Convent Convent

18. (a) Signature of funeral director Wadell Phyllis

(b) Address Convent St. Mo

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 H. C. Bauman (M. D. or other)  
Address 131 S. Main Date signed 11/19/47

19. (a) 7/23/47 (Date received local registrar)

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

**STATEMENT BY LICENSED EMBALMER**

*Not Embalmed*

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ~~embalmed~~ *not embalmed* by me, or by

..... Registered Apprentice No. ....

~~working under my personal supervision.~~

Signed *Leroy H. Phillips*

Licensed Embalmer No. *1898*

P. O. Address *Stonbury 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. 250

Primary Registration District No. 4374

1. PLACE OF DEATH:

(a) County nodaway

(b) City or town clay  
(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

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Mary E. Loues

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife same

6. (c) Age of husband or wife if alive none

7. Birth date of deceased June 9  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_  
if less than one day

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

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

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

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

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)

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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)

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) (c) Means of injury

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

