

FILED SEP 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27463

Registration District No. 122

Primary Registration District No. 4201

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Republic
(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 Mo (b) County Greene
(c) City or town Republic
(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

Rosa Bell Merritt

3. (b) If veteran, name war _____

3. (c) Social Security No. 488-24193

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife James Merritt 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased June 25-1897
(Month) (Day) (Year)

8. AGE: Years 50 Months 2 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

MOTHER FATHER 11. Industry or business _____

12. Name Hannibal Stokes

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

14. Maiden name Bell Stokes

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

16. (a) Informant Mrs. Bell Stokes

(b) Address Clever, Mo.

17. (a) Burial (b) Date thereof Aug 30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Delaware Chapel

18. (a) Signature of funeral director J.W. Maples

(b) Address Clever, Mo.

19. (a) Aug 30-1947 (b) Glennie Brittain
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28 year 1947 hour 12 minute 25 A. M.

21. I hereby certify that I attended the deceased from Aug 26 1947, to Aug 28 1947;
that I last saw her alive on Aug 28 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Basilar Haemorrhage with complete Paresis Duration _____

Due to _____

Due to Natural Causes.

Other conditions _____ (Includes pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy none

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 E. J. Beal M.D. (M. D. or other) _____
Address Republic Mo. Date signed 9/29/47

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

RECEIVED

Greene County Health Office,

County File Number 47-8-47

Date Filed 9/3/47

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 J. W. Maples

Licensed Embalmer No. 2985

P. O. Address: Gleener 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.