

FILED SEP 2 1947

Registration District No. **251**

Primary Registration District No. **308**

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2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Nodaway**

(b) City or town **Maryville, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Francis Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 Hrs.** (Specify whether years, months or days)

In this community **3 Hrs.**

3. (a) PRINT FULL NAME **MARY ANN SPIRE**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** / 5. Color or race **White** / 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August 16, 1947**
(Month) (Day) (Year)

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

9. Birthplace **Maryville Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business **None**

MOTHER FATHER

12. Name **Robert Spire**

13. Birthplace **Parnell Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Kathleen Manning**

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

16. (a) Informant **Robert Spire**

(b) Address **Parnell, Missouri**

17. (a) **Burial** (b) Date thereof **8-17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Joseph Cemetery**

18. (c) Signature of funeral director: **Price Funeral Home**

(b) Address **120 East 1st, Maryville, Mo.**

19. (a) **8-20-47** (b) **Bess Holt**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Nodaway**

(c) City or town **Maryville**
(If outside city or town limits, write "RURAL")

(d) Street No. **St. Francis Hospital**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **17**
year **1947** hour **1** minute **00** A. M.

21. I hereby certify that I attended the deceased from **Aug 17** 19 **Aug 17** 1947
that I last saw her alive on **Aug 17** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Premature Development** (Duration **5-6 hrs**)

Due to **6 Months Antelion**

Due to _____

Other conditions **Premature Labor**
(Include pregnancy within 6 months of death) **Cause Unknown**

Major findings:
Of operations _____

Of autopsy **159**

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 **0**

23. Signature **W.R. Johnson** (M. D. or other) _____
Address **Maryville, Mo** Date signed **8-18-47**

**DISTRICT HEALTH OFFICE
COLUMBIA, 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.