

FILED SEP 15 1947

Registration District No. 277

Primary Registration District No. 4411

Registrar's No. 33

1. PLACE OF DEATH:

(a) County PIKE
 (b) City or town BOWLING GREEN
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: NONE - Home!
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 1000 DAY years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County PIKE 820
 (c) City or town BOWLING GREEN, MO (RURAL)
 (If outside city or town limits, write "RURAL")
 (d) Street No. RFD #4
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME DAWNEETA RAE JETT

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 0
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased AUGUST 15 1947
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. 5 UNKNOWN min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name ALBERT GIBBS JETT
 13. Birthplace BOWLING GREEN MO
 (City, town, or county) (State or foreign country)
 14. Maiden name EVA BIRDELWA MITSON
 15. Birthplace STOCKTON CALIF.
 (City, town, or county) (State or foreign country)

16. (a) Informant MOTHER
 (b) Address BOWLING GREEN MO

17. (a) Burial (b) Date thereof 8/16/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Overwestern Louisiana Mo.

18. (a) Signature of funeral director Haley Mortuary

(b) Address Louisiana Mo.

19. (a) 9-2-47 (b) Bill Johnson
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day FIFTEEN
 year 1947 hour 2:00 PM minute UNKNOWN

21. I hereby certify that I attended the deceased from 1:30 AM
AUGUST 15, 1947, to 1:00 PM, 1947
 that I last saw her alive on 1:00 PM, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death MYOCARDIAL FAILURE
 Duration LESS THAN 1 HOUR

Due to _____

Due to _____

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

Major findings: 157E

Of operations _____

Of autopsy _____

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?
no.

While at work? _____ (Specify type of place)
 (e) Means of injury 2

23. Signature Emil Prayn (M. D. or other) DD
 Address 213 1/2 GEORGIA ST. Date signed 8/16/47

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

RECEIVED
District Health Officer No. 10
District File Number 9-47-1229
Date Filed SEP 12 1947

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 *George O. Wagner*

Licensed Embalmer No. *3773*

P. O. Address *Louisiana, La.*

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.