

No. 2
12-45
-17-39
X47070

FILED AUG 29 1947

Primary Registration District No. **6148**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Stoddard**

(b) City or town **Bloomfield, Mo. R. 1**
(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 **Missouri** (b) County **Stoddard** / 03

(c) City or town **Avert, Mo.**
(If outside city or town limits, write "RURAL") 525

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Anna Mayberry**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** race **White** 5. Color or race _____

6. (b) Name of husband or wife **George Mayberry** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **March 1 1875**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **13** year **1947** hour **6** minute **26P.** M.

21. I hereby certify that I attended the deceased from **March 15**, 19**46**, to **Aug 9**, 19**47**
that I last saw her alive on **Aug 9**, 19**47**
and that death occurred on the date and hour stated above.

8. AGE: Years **65** Months **5** Days **12** If less than one day hr. _____ min. _____

Immediate cause of death **Chronic Myocarditis with myocardial degeneration (arrhythmia fibrillans) 3 yrs.**

Due to **Thyroxinosis** Duration **4 yrs.**

Due to **Juvenile (cause?) feminine**

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

9. Birthplace **Bloomfield, Mo. R. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Farming**

MOTHER FATHER { 12. Name **Francis Blocker, unknown**

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

14. Maiden name **Susie Bend**

15. Birthplace **Bloomfield, Mo. R. 1**
(City, town, or county) (State or foreign country)

Major findings: **Toxic goiter** PHYSICIAN _____

Of operations _____

Of autopsy **None performed**

Underline the cause to which death should be charged statistically.

16. (a) Informant **George Mayberry**

(b) Address **Avert Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8.14.47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Gravel Hill, Cem.**

18. (a) Signature of funeral director **Watkins Funeral Ser.**

(b) Address **Bloomfield, Mo.**

19. (a) **Aug 22, 1947** (b) **Rose Webb**
(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)

(e) Means of injury _____

23. Signature **J. J. Harris** (M. D. or other) **MO**

Address **Bloomfield Mo** Date signed **8-15-47**

RECEIVED

District Health Office No. 2, 11

District File Number 849-3446

Date Filed 8-25-77

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.....

Lynnan Steele

Licensed Embalmer No. 2476

P. O. Address Hester 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. 338 Primary Registration District No. 6148

1. PLACE OF DEATH: Stoddard
(a) County _____
(b) City or town _____
(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

3. (a) PRINT FULL NAME Anna Mayberry
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife George March 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased March 17 1899
(Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M. 3
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-30096