. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 13 1947

Registration District No. 3048

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3048

State File No. 31946

Registrar's No. 512

1. PLACE OF DEATH:
(a) County: NODAWAY
(b) City or town: MARYVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. FRANCIS 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5days (Specify whether years, months or days)
In this community: 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Atchison 3
(c) City or town: Tarkio Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME: Maffit Frances Angel
3. (b) If veteran, name war:
3. (c) Social Security No.

4. Sex: female 1
5. Color or race: white
6. (a) Single, widowed, married, divorced: widowed 2
6. (b) Name of husband or wife: Thomas Angel
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: August (Month) 15 (Day) 1867 (Year)

8. AGE: Years 80 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace: Holt (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation: at home
11. Industry or business:
FATHER 12. Name: George Chapman
13. Birthplace: Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Nancy Sharp
15. Birthplace: Missouri (City, town, or county) (State or foreign country) 0
16. (a) Informant: Thomas Angel Jr
(b) Address: Tarkio Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 23 47 (Month) (Day) (Year)
(c) Place: burial or cremation: Tarkio Home Cemetery
18. (a) Signature of funeral director: J M Lairs
(b) Address: Tarkio Mo.
19. (a) 9/26/47 (Date received local registrar) (b) Bess Holt (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: September 19 year: 1947 hour: 7 minute: 20 a.m.

21. I hereby certify that I attended the deceased from Sept 16 47 to Sept 19 1947 19..; that I last saw the deceased alive on Sept 18 1947 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Hemiplegia Rt side
Due to: Cerebral Rupture left Menin
Due to: Hypertension
Due to: Senility
Other conditions (Include pregnancy within 3 months of death): 0
Major findings: Of operations: 0
Of autopsy:

Duration

PHYSICIAN
Underline the cause of 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? (Specify type of place) 0
While at work? (e) Means of injury:

23. Signature: Chas T Lee (M. D. or other) M.D.
Address: Maryville Mo Date signed: 9/25/1947

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, 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 Frost A. Browning

Licensed Embalmer No. 333 S

P. O. Address Darlow, 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.