V. S. No. 2
00M—5-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33745

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1255

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 4 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Doniphan 399

(c) City or town Wathena 14
(If outside city or town limits, write "RURAL")

(d) Street No. Box 51 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country —

3. (a) PRINT FULL NAME Leverdia Mabin

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 3

5. Color or race Negro

6. (a) ~~Single, widowed~~, married, ~~divorced~~ married

6. (b) Name of husband ~~or wife~~ Eugene Allen Mabin

6. (c) Age of husband ~~or wife if~~ alive 32 years

7. Birth date of deceased April (Month) 9 (Day) 1922 (Year)

8. AGE:

Years	Months	Days	If less than one day
24	6	7	— hr. — min.

9. Birthplace Rankin County (City, town, or county) Miss. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housewife

FATHER
12. Name John Myers, Sr.
13. Birthplace Rankin County (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Lillie Mae Willis
15. Birthplace Rankin County (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Eugene Allen Mabin

(b) Address Box 51 - Wathena, Kansas

17. (a) Removal (~~Burial, cremation~~, or removal) (b) Date thereof 10-19-47 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ Florence Miss.

18. (a) Signature of funeral director Wm. H. Alexander

(b) Address St. Joseph Missouri

19. (a) 10-21-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) 207

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 16 year 1947 hour 4:00 minute P. M.

21. I hereby certify that I attended the deceased from 10-13-47, 19__, to 10-16-47, 19__; that I last saw her alive on 10-16-1947, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tetanus	5 days
Due to Abortion, Incomplete Septic	9 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

140-B

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature H. C. Senne (M. D. or ~~other~~)

Address 207 P&S Bldg St. Joseph Mo. Date signed 10-17-47

(Licensed Embalmer's Statement on Reverse Side)

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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.