

**FILED OCT 20 1947**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1231

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph

(c) Name of hospital or institution: Mo. M.E. Hospital  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution TWO Weeks  
2 weeks (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County De Kalb **32**

(c) City or town Maysville Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lena K. Terry

3. (b) If veteran, name war ----

3. (c) Social Security No. ----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9 year 1947 hour 7:15 minute P.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Clarence Terry

6. (c) Age of husband or wife if alive 74 years February 18 1878

7. Birth date of deceased (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 26 1947 to Sept 7 1947 that I last saw her alive on Oct 9 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration Instant

8. AGE: Years Months Days If less than one day

60 69 7 21 hr. min.

Due to Arteriosclerosis, General Myocarditis unknown

Due to \_\_\_\_\_

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

Other conditions Hypertension Primary (Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none **93H**

10. Usual occupation House wife

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name Samuel Kranbul

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

14. Maiden name Kathern Rinehart

15. Birthplace Switzerland (City, town, or county) (State or foreign country)

16. (a) Informant Clarence Terry

(b) Address Maysville Mo

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-47 (Month) (Day) (Year)

(c) Place: burial or cremation Butler Cemetery

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? (c) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director John Brown

(b) Address Maysville Mo

19. (a) 10-16-47 (Date received local registrar) (b) E. B. Jenkins (Registrar's signature) 109

23. Signature E. M. Shores (M. D. or other) M.D.

Address St Joseph Mo Date signed 10-13-47

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

**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 John G. Bra

Licensed Embalmer No. 3933

P. O. Address Weymouth

**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.**