

FILED DEC 6 1947

Registration District No. **3008**

Primary Registration District No. **3008**

Registrar's No. **414**

1. PLACE OF DEATH:

(a) County **Calloway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 months** (Specify whether
In this community **Same** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Monteair**
(c) City or town **California** 14
(If outside city or town limits, write "RURAL")
(d) Street No. **1**
(If rural, give location) **2**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **ANNA EBERHARDT**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S D**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **years 47**
7. Birth date of deceased **Dec 17 1864**
(Month) (Day) (Year)

8. AGE: Years **87** Months **11** Days **10** If less than one day hr. min.

9. Birthplace **Mo U**
(City, town, or county) (State or foreign country)

10. Usual occupation **Honourwife**

11. Industry or business _____

MOTHER FATHER
12. Name **DK** **a**
13. Birthplace **DK** (City, town, or county) (State or foreign country)
14. Maiden name **a**
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Hospit Records State Hospit**

(b) Address **Fulton Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-30-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Evangelical Cemetery**

18. (a) Signature of funeral director **Hugh E. Williams**

(b) Address **California**

19. (a) **11-28-1947** (Date received local registrar) (b) **Josia Mansfield** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **27**
year **1947** hour **4** minute **9 a** M.
21. I hereby certify that I attended the deceased from **Nov 26** 19**47**, to **Nov 27** 19**47**,
that I last saw her alive on **Nov 26** 19**47**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to _____
Due to _____
Other conditions **Sen artus Schures**
(Include pregnancy within 3 months of death)
Major findings:
Of operations **83**
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? _____

23. While at work? _____ (Specify type of place) (e) Means of injury **0**

Signature **R. Price** (M. D. or other) **11-28-47**
Address **Fulton Mo** Date signed **11-28-47**

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

Date Filed 12-3-47

District File Number

District Health Officer No. 9,

RECEIVED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the _____ side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed Angelo E. Williams

Licensed Embalmer No. 3537

P. O. Address California Ave.

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 on reverse.