S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38710

FILED DEC 5 1947

Registration District No. 155

Primary Registration District No. 5579

Registrar's No. 175

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

1. PLACE OF DEATH:
(a) County JASPER
(b) City or town RURAL MINERAL TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ORONOGO MO R.R. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 30 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper 49
(c) City or town Rural MINERAL TWP.
(If outside city or town limits, write "RURAL")
(d) Street No. Oronogo, Mo RR 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME CELIA MAY FALLON
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 Married
6. (b) Name of husband or wife JAMES FALLON
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased Dec 8 (Month) 8 (Day) 1870 (Year)

8. AGE: Years 76 Months 11 Days 14 If less than one day ..... hr. ..... min.

9. Birthplace SARNACK (City, town, or county) NEW YORK (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business .....
FATHER
12. Name MILO EVANS
13. Birthplace ..... (City, town, or county) N. Y. (State or foreign country)
MOTHER
14. Maiden name LUCY WARD
15. Birthplace ..... (City, town, or county) N. Y. (State or foreign country)
16. (a) Informant JAMES FALLON
(b) Address ORONOGO, MO R.R. 1
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 24 1947 (Month) (Day) (Year)
(c) Place: burial or cremation WEAVER CEMETERY
18. (a) Signature of funeral director JOHNSTON ARNCE SIMPSON MORTUARY
(b) Address 26 S ROANE ST WEBB CITY MO
19. (a) NOV. 24; 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 22
year 47 hour 1 P.M. minute — M.

21. I hereby certify that I attended the deceased from Oct. 8, 1947, to NOV. 22, 1947; that I last saw her alive on NOV. 21, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial Failure	8 hrs.
Due to Chronic Myocarditis	years
Due to	
Other conditions Chronic Nephritis (Include pregnancy within 3 months of death)	yrs.

Major findings:
Of operations .....
Of autopsy .....

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)
While at work? ..... (e) Means of injury 2

23. Signature Glenn Q. Duey (M. D. or other) D.O.
Address Alba, Mo Date signed 11-24-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

47-11-888

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 Jack C. Simpson, Registered Apprentice No. 38, working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.