S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 24 1947

Registration District No. 755

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38724

Primary Registration District No. 4244

Registrar's No. 163

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

1. PLACE OF DEATH:
(a) County JASPER
(b) City or town CARTERVILLE MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 701 N. TENNESSEE 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 10 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County JASPER 49
(c) City or town CARTERVILLE 4
(If outside city or town limits, write "RURAL")
(d) Street No. 701 N. TENNESSEE 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME MARY C.M. TWIVEY
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or ~~wife~~ JOHN T. TWIVEY
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased N. Data (Month) (Day) 1866 (Year)

8. AGE: Years 81 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (City, town, or county) IOWA 1 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant John T. TWIVEY Carterville
(b) Address 701 N. TENNESSE MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 5 1947 (Month) (Day) (Year)
(c) Place: burial or cremation CARTERVILLE Cem
18. (a) Signature of funeral director JOHNSTON-ARNCE-SIMPSON
(b) Address 26 S. ROANE ST. WC. MO
19. (a) 11-4-47 (Date received local registrar) (b) [illegible] MD (Registrar's signature) 129

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 3
year 1947 hour 3 minute 40 P. M.
21. I hereby certify that I attended the deceased from Oct 15, 1935, to Nov 3, 1947;
that I last saw her alive on 10 day 11/3/47;
and that death occurred on the date and hour stated above.

Immediate cause of death Tobacco Myo Cardiitis

Due to Cardio vascular renal disease

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 9 3D
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)
While at work? (e) Means of injury 0
23. Signature R. M. Stonecrest (M. D. or other)
Address Webb City Mo Date signed 11/4/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

47-11-878

JUN 23 1948

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 Wells 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.