

FILED DEC 12 1947

Registration District No. **2291**

Primary Registration District No. **4433**

Registrar's No. **104**

1. PLACE OF DEATH:

(a) County **PUTNAM**
(b) City or town **UNIONVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MONROE HOSPITAL and CLINIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 DAYS**
(Specify whether years, months or days)
In this community **75 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **PUTNAM**
(c) City or town **"RURAL"**
(If outside city or town limits, write "RURAL")
(d) Street No. **UNIONVILLE**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **16**
year **1947** hour **5** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **June 12**, 1944, to **Nov. 16**, 1947
that I last saw her alive on **Nov. 15**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic poisoning
Due to **Chronic glomerular nephritis**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
13/18
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
23. Signature **C. W. McDonald** (M. D. or other) **DO**
Address **Unionville, MO** Date signed **11-17-47**

3. (a) PRINT FULL NAME **SALLIE ANN MOWER**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **JOHN ANDREW MOWER** 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased **DECEMBER 27 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 10 19 hr. min.

9. Birthplace **MARSHALLTOWN IOWA**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWORK**

11. Industry or business **HOUSEHOLD**

12. Name **BENJAMIA F. TODD**

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

14. Maiden name **SARAH ELIZABETH McCLINE**

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

16. (a) Informant **Rev. H. W. ...**
(b) Address **Unionville MO**

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

(c) Place: burial or cremation **UNIONVILLE CEMETERY**

18. (d) Signature of funeral director **COMSTOCK FUNERAL HOME**

(b) Address **UNIONVILLE MO. By, John H. ...**

19. (a) **11-3-47** (b) **Marshall Durbin**
(Date received local registrar) (Registrar's signature)

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

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DEC 15 1947
RECEIVED
District Health Officer No. 10
District File Number 12-47-1711
Date Filed DEC 10 1947

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 N. Comstock
Licensed Embalmer No. 3891
P. O. Address Unionville, 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.